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Sex Pathology

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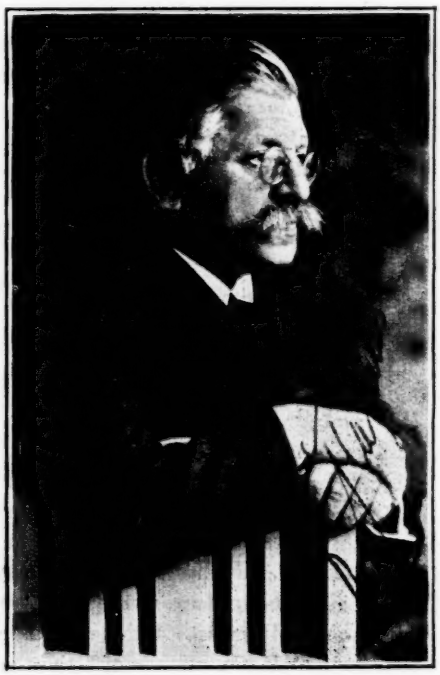
Mr. Chairman, Ladies and Gentlemen,

It is for me indeed a very great satisfaction that I have today the opportunity to deliver a lecture about "SEX PATHOLOGY", in the Bengal Branch of the Indian Medical Association.



I will at first give a short outline on the presentday knowledge about the sufferings of love. Then I will explain to you the psycho-biological questionnaire from our Institute for Sexology in Berlin and afterwards I hope you will ask me questions about this important part of our medical science and profession.

It is about 50 years since the fundamental work on sex-pathology has appeared—Krafft-Ebing's "Psychopathia Sexualis". This book meant action and deliverance for innumerable men and women, but much as we are entitled to count it to the classical works of medical world literature, it is nevertheless necessary to emphasize that, according to present day standards of sex-science, it is only an extremely large and minute compilation of cases with subsequent correct conclusions. What is missing, however, is the organical connection, the objective foundation from which disturbances of the sexual impulse are uniformly derived. Such a principal view point has in the decades past since, been found by the scientific investigations of many authors, *viz.*, the doctrine of psycho-incretoric parallelism. By this we mean the reciprocal effect between the individual sex constitution and psychical influences. The sex-constitutional formula, however, is a glandular formula depending on the sexual glands and those glands with internal secretion, which are in connection with them. The four main sex constitutions are—two normal ones, *viz.* the fully masculine and the fully feminine one, and two abnormal ones, the intersexual one and the infantile one. They are all very different in degree and this is on the one hand depending on the different degree of male and female

heredity, on the other hand on the strength of development itself.

Besides the parallelism of body, soul and sex there is another parallelism between age and sex. From puberty to the change of life there is a periodical rhythm of life which is narrowly connected with the evolution and involution of glands.

We are giving here a few proofs for the soundness of the doctrine of psycho-incretoric parallelism.

A. The physical and psychical deficiency-symptoms, which can regularly be observed after removing the sexual glands in animals and men, place the connection between internal secretion and physical and psychical attitude beyond any question.

B. The removal of these deficiency-symptoms by grafting the glands or introducing the hormones as STEINACH has been doing most successfully, form a further support of this theory.

C. The proof of mixed sexual glands in physico-psychical hybrids in animals as well as in man, particularly the discovery of the Testovar complete the supposition that the sex-type of the total personality is dependent upon incretoric conditions.

If we consider this view as a basis, a clear connection is created between the various sexual disturbances, and a classification is obtained, which had been impossible at the times of KRAFFT-EBING because the decisive results of research on internal secretion and constitution has been won only after his death.

Three main groups of disturbances of the sexual impulse have resulted, each with a number of sub-divisions, in all sixteen different sex-types; deficiency of the sexual glands is above all counted to the first main group. In case of entire lack of the sex-glands hormone, we can find three sex-types, the difference between which most probably originates in the simultaneous affection of other incretoric glands:

A. The tall-types
B. The obese-types
C. The short-types

Connected with the latter group is sexsual infantilism, a second disturbance of development which is of practical importance, because cases of this group may easily become criminal by violating individuals of immature sex. In contrast to them, we see the third group—sexually premature persons in which the purely physical development of sex prevails, as for instance in girls menstruating before their tenth year of age, or psychical sex development as in individuals, whose imagination is filled with sexual ideas even in early childhood.

The fourth disturbance of development is formed by the so-called sex-crises, which appear during the age of puberty, and which resemble to those, during the time of involution of the sexual glands, the so-called change of life (climacterium). Menstrual crisis and mental disturbances during pregnancy belong to the same group. Here we can observe minor psychical alterations, like depression and exaltation, but also serious ones, like Hebephrenia and the grave melancholias of ageing women. To a certain extent ipsation may be considered as the fifth disturbance of development, which is so often found as a self-relief of juvenile individuals and a frequent source of inferiority-complex. The sixth disturbance of development is also a kind of auto-satisfaction and is called narcissmus, a form of sexual self-reflexion which even beyond the years of development renounces a sexual partner.

The second principal group is formed by the intersexual variations. Here we discern four forms of masculo-feminine sex mixture: the general physical constitution form a mixture of masculine and feminine sex-characters; the psychical hermaphrodites or transvestites, whose psychical character does not seem to conform with their actual sex: feminine men and masculine women; finally as a fourth group, the hermaphrodites by sexual impulse who again may be sub-divided into two groups; the metatropical and the homosexual group. In the instance of metatropism supplementation of the sexual impulse is accomplished by manly women and womanly men, feeling attracted to each other. In homosexuality the sexual impulse is no longer directed towards persons of the opposite sex, but

the homosexual woman feels herself spontaneously attracted by females just like a man, and the homosexual man shows a sexual impulse normally characteristic of women, and therefore chooses male persons for his object.

All these different sexual types show innumerable variations and are caused by the constitution, the psychical effect, however, is different as it as not only dependant on sexual impulse, but also on sexual inhibition. The third and last group is considered as a disturbance of sexual metabolism. Metabolism is just as well present in the sexual sphere, as in nutrition, it is only much more complicated. Here we have the following three sub-divisions :

A. Quantitative alterations, *i. e.* increase and decrease of sex-impulse.
B. Sexual repression.
C. Rudimentary sex-forms, which, where impressions are concerned, are called fetishism, where expressions are concerned, are called exhibitionism.

Among quantitative alterations hyper-erotism is first on the excessive side and can be increased to sadism and lust murder : its counterpart on the defective side is impotence of the man and frigidity of the woman, in which we may sometimes see inhibition, sometimes a loading disturbance.

Sexual repression is mainly followed by sexual neurosis for the investigation of which Prof. FREUD of Vienna has lately earned great merit. All sorts of cases of hysteria, hypochondria, and phobias belong to this concern, and it must be emphasised that sexual repression should be looked upon as the cause not only of deficient, but also of inadequate impulse-relief.

In fetishism, in exhibitionism, patients are satisfied with rudiments, by being attracted to parts of the body or even to part of the clothing, instead of the whole person, or as far as exhibitionists are concerned, by foolish self-denudations instead of the real sexual act.

The time at our disposal does not permit to discuss the therapy of all these disturbances. Although the physician cannot heal most of these cases, he can, nevertheless, help a great deal. In some cases, as for instance in infantilism, the removal of the sexual glands has proven itself very useful, in so far as such patients, and with them, humanity, have been liberated from the dangers of this unfortunate impulse-disturbance. In several other cases, in the most serious ones similar success can be reported. In many, particularly the socially harmless disturbances, before all, homosexuality, environment-therapy renders good service. Also in other disturbances much can be effected by psycho-therapy, organo-therapy and other means, but before all, it is the physician's duty to admit the knowledge of these phenomena into the treasure of his science, because otherwise he would lack the understanding and with this lack of understanding, the confidence of many people. *

Psychobiological Questions, Issued by The Institute for Sexology in Berlin.

I. PERSONAL DATE, as age, name, sex, etc.
II. DESCENT.
1. Are your parents alive and healthy, what do they suffer from or what did they die of ?
2. Are parents or grandparents consanguinous ?
3. Any consanguinous marriage in your family ? What ?
4. Age of parents when you were born ?
5. Are you a legitimate child ?
6. Did you resemble father or mother ? (physically ? mentally ?) Mother's and father's character. Profession of the father ?
7. Number and sequence of brothers and sisters ?
8. Is it known to you whether your parents, before you were born, desired more a boy or a girl ?
9. Was the married life of your parents happy ? Love match or other reasons (money) for the marriage.
10. Education tender or strict ? Did you ever suppress tender or hostile feelings against father or mother ?
11. How did you get along with sisters and brothers ? What are the strongest impressions of your childhood ?
12. Did any of your nearer relatives suffer from mental or nervous disorders ?
13. How did your parents act with regard to smoking and drinking ?
14. Any suicides or attempts at suicide in your family ?
15. Did any of your relatives get into trouble with the law in a singular way ?
16. Are any of your relatives aged 30 or more unmarried ? Any of your brothers and sisters married ?

* Lecture delivered at the Bengal Branch of the Indian Medical Association on the 4th October, 1931.

17. Does any of your male relatives behave, act and look like a woman or *vice versa* ?

18. Any abnormal sexual desire in any of your relatives ?

III. CHILDHOOD AND YOUTH.

19. When did you learn walking and talking ?

20. Was your health always satisfactory ? Did you stutter or lisp ?

21. Have you been timid and fearful ? Often alone, shy, obedient, lively, jolly, easy to educate ?

22. Did you chew your nails, suck your thumb, pick in the nose, (steal, loaf, sneak) ? When did these habits disappear ?

23. **Did you prefer to play with boys or girls ?**

24. Did you, before maturity, look remarkably girlish or, particularly boyish ? Were remarks made as "he looks like a girl" or "she is a real boy" ? (tomboy)

26. **Do you remember any dreams of your childhood especially those you had often ?**

27. **Did you get any strong shock during your childhood ?**

28. School life ? Educated in your home or public schools, boarding schools etc ?

29. Did you suffer bodily punishment from your parents or teachers or were you otherwise corporally punished ? What kind of punishment ? Did you suffer (or in what way have you been punished) ?

30. How were you educated ? Were you brought up with many others in a boarding school, convent, military school or at home ? How was your college life ? Were there any sexual seducings by some aged, younger or older persons ? From the masculine or feminine side ? Were you brought up in a big city, provincial town or in the country ?

31. Any enthusiastic friendships for grown-up persons, other boys or girls ?

32. Did you sleep in the same room or bed with grown-up persons ?

33. When did you first hear about sexual things ?

34. Did you ever watch during your childhood cohabitation between human beings or animals ?

35. Did you do any masturbation ? What ? And under what imaginations ?

36. At what age were you completely developed as regards sex ?

37. At what age did other marks of maturity develop (for example : low or deep voice, growth of moustache by men, swelling of the breast by women) ? Has your voice changed again, later on after maturity (has it become higher) ? Did you notice, at the same time, if you are masculine, a light swelling of your breast ? If you are feminine, that your voice became lower or that you developed hair growth ?

38. First sexual intercourse and under what conditions ?

IV. PRESENT STATE.

A. PHYSICAL ATTRIBUTES AND CONDITIONS.

The underlined questions are to be answered also with regard to that which you like in other persons e.g. I am tall but I like small women.

39. **Height of body, weight ?**

40. **Muscles strong or weak ?**

41. What kind of physical exercise do you prefer ? Sports ? or dancing and rythmic ? **Are arms or legs stronger developed ?**

42. Do you whistle ?

43. **Kind of walking.**

44. Complexion dark or light, clean or unclean ?

45. **Hair ?** also with regard to your body.

46. Pulse ? Do you blush easily ?

47. Are you very sensitive as far as pain is concerned ?

48. Size of hand and foot ? How do you shake hands ? With or without pressure ?

49. How is your handwriting ? Changing or always the same ?

50. **Are the lines of your body slim and slender or round or cornered ?** Especially with regard to the shoulders.

51. Are your hips broader than your shoulders ? Size of skull ?

52. **How are your breasts ?** Flat, round, meagre ?

53. How are your ears, big, small, tiny ? By any means extraordinary ?

54. How are your eyes ? Colour ? Is your look steady or uneasy, soft, enthusiastic, coquettish, or what else ?

55. Are you fond of special smells ? **Do you love perfumes ?**

56. Any predilection for sweet, bitter, sour or salty dishes ?

57. Photo, if possible, also of the person that is most to your taste. Is your expression more male or female ? (Are you typical of your race ?)

58. Construction of the larynx ? Have you an Adam's apple, strong, little ? Size of collars ? **Is your voice low or high, loud or soft ?** Is your way of talking natural or affected ?

59. Are you able to sing ? What voice ? Any predilection to speak in a very high or very low voice ?

60. Left-handed ?

61. **Are there or have there been any disorders in your nervous system** as headaches, permanent tiredness, restlessness, trembling, fainting, lack of concentration, fear of blushing, cramps, temporary absence of mind, blues, irritation without reason ? Any accident and how did your system react to it ?

62. Any physical defects on the genitals or near them ? Did you ever suffer from a venereal disease ? Regular menstruation ? Is same weak or strong ? Is it accompanied by physical or mental depressions ?

B. MENTAL ATTRIBUTES AND CONDITIONS.

63. Is your nature soft or hard ?

64. Has joy and greif a strong influence on you ? Are you very fond of weeping or laughing ? Have you ever laughing or crying fits ?
65. Is your nature evenly quiet or restless ? Did you ever suffer from the desire to express your feelings without being able to do so ?
66. Are you at certain times of the week or month more nervous and depressed than at other times ? More or less capable of work ? Are you subject to long periods of depression ?
67. Are you easily irritated, furious, exalted ?
68. Have you a strong family sense ? Are you particularly affectionate towards father, mother, home, or fatherland ?
69. Are you goodhearted, obliging, selfsacrificing, philanthropic, longing for love ?
70. Are you ambitious to a great extent ? Do you overestimate yourself, are you fond of admiration, fond of bossing ?
71. Are you talkative, curious, discreet ? Fond of gossip ? Distrustful or credulous ?
72. Your thoughts about religion ? Are you superstitious, fond of spiritism etc ? Any of your own impressions led you to your opinion ?
73. Fond of adventuring, romance or loafing ?
74. Are you tidy (pedantically) or disorderly, punctual or unpunctual ? Prodigal or economical or stingy ?
75. Do you suffer from any unsatisfied urges or imaginations ?
76. Are you easy to reconcile or not ?
77. Strong or weak will-power, energy, courage or timidity ?
78. Do you like luxury or do you mind living modestly ? Do you prefer physical work, or mental or leisure ?
79. How about drinking and smoking ? Are you able to stand alcoholic drinks ? (What do you prefer : wine, beer, champagne ?) Have you been taking any drugs ? Since when ? Do you eat much meat ? Are you vegetarian ?
80. How is your memory, attention, imagination ? Do you like to invent fantastic stories ? Are you fond of pretending that your wishes and hopes have already materialized ? Do you get easily under the influence of personalities or ideas **against** your own will ?
81. Is your character productive, critical, receptive ? Do you pick up things easier through your eyes then by reading ?
82. Are you gifted for mathematics and abstract thinking ? Have you any talent for sculpturing or painting ? Any literary gifts ? Are you fond of reading ? What subjects (science, poetry, novels, criminal stories, newspapers, humor) ? Are you found of writing letters ? Do you write anonymous letters ?
83. **How about music** ? Musical or not ? Fond of music ? Do you play any instrument ? Does music excite you in a sexual way ? What kind of music ?
84. Are you fond of and gifted for acting ?
85. In what great personalities are you mostly interested ? Who is or was your ideal ?
    A. In the past.
    B. At present.
86. Are you fond of certain occupations such as sports, hunting, shooting, etc. or cooking, needlework etc ? What are you mostly interested in. (the stage, politics, horses, flowers, history etc.) ?
87. Do you take part in political life ?
88. What do you think about the world-war ?
89. Are you satisfied with your profession or do you feel attracted to other professions ? Which ?
90. Do you put much stress on your dress ? Do you prefer tight or loose garments ? Free or closed neck ? Are you very fond of jewellery or not ? Are you particularly fond of a certain colour ? Which ?
91. What do you usually carry in your Pocket ? (Powder box, pocket-knife, lighter, photos ?)
92. Are you popular or unpopular ? Do you like society ? Do you prefer to live in the country, by the seashore, in the mountains, in a big or small city ?
93. Do you have any special merits or efficiencies ? Do you find any faults with yourself physically or mentally ?

C. Sexual Desire.

94. Do you have any sexual desire or do you lack them entirely ?
95. Which sex are those desires driving you to ?
96. Did you notice whether the direction of your urge changed during puberty ? Or has it always been the same ?
97. Do you love persons older or younger than yourself or of the same age ? What are the approximate limits in age of the persons by whom you feel attracted ?
98. Are you attracted by persons of the same social standing, higher or lower ? Do you prefer refined and softhearted or rough and strong natures ? Do you like persons whom you can educate ?
99. Through what impression is your attraction based ?
    (*a*) Through looking ? What part of face or body seems to you to be especially beautiful ? Does a nude, half-dressed or undressed body excite you ?
    (*b*) Through hearing ? Does the voice attract you particularly ?
    (*c*) Through feelings ? Does soft skin or hard muscles excite you ?
    (*d*) Through smelling ? Do certain smells of persons you are interested in attract you or repel you ?
    (*e*) Or do you think that the attraction is mainly based on mental features and attributes (character, will, intellect) ?

100. Do you love persons because of those features, assets and attributes of which you possess yourself also, or because of those which you have not got ? *e. g.* height, colour of hair, mental education, intellect ?

101. Is your sexual urge directed towards very expressed types of the opposite sex (strong "he-men" or "she women") ? Or do you prefer *e. g.* very energetic women or tender men ?

102. What sex was concerned in erotic dreams of yours ?

103. In public, on the street, in theatres etc. do men or women attract your attention ?

104. Are you interested in pictures, photos etc. of men or women ?

105. Towards which sex do you feel easier ? Are you shy in the presence of men or women ?

106. Are your affections hasty and inconsiderate or long lasting ? Did you suffer very much from the loss of a beloved person and how did you overcome it ?

107. What is in your opinion the difference between friendship and love in your life ?

108. Have you been engaged ? Did you break engagements often ?

109. Have you been married and for what reason ? How was or is your married life ?

110. Have you children ? Do you notice anything in them as far as sexuality is concerned ?

111. How was the intensity and the control of your sexual urge ? Do you think that the sexual urge can be controlled in the long run ? Did you try to suppress the urge and with what results ?

112. In the average how often did intercourse take place ? Is your behaviour in this active or passive ?

113. What kind of sexual satisfaction do you prefer ?

114. Have you ever been indifferent to the normal act ?

115. Did you go often to prostitutes ? Or did you feel disgusted ?

116. Do you need during intercourse to imagine a person other than the one you are just with ?

117. Is your sexual urge always concentrated on persons of one sex or on both sexes at the same time ? Is the attraction of the same or the other sex stronger ?

118. Did you ever have any desire towards immature persons ?

119. Was there any love towards old men or women ?

120. Did you notice any sadism in yourself ?

121. Or masochism ?

122. Did you have a passion for certain parts of the body, certain articles of clothes or certain materials (furs, silk etc.) ? What parts or things are these ? (Fetishism)

123. Do you have a strong disgust for certain parts or things ? (Antifetishism).

124. Do you like to display yourself, and for what reasons ? (Exhibitionism).

125. Does it excite you to put on the clothes of the other sex ? what do you feel when doing so ?

126. Do you like certain fancy dresses ? *e. g.* those of young people ?

127. Are you in love with your owa body ? (Narcism).

128. Are you fond of watching people doing certain indiscreet things ?

129. Does sexual intercourse of three persons excite you ? What kind ?

130. Did animals ever excite you sexually ?

131. Do you suffer from any other—not mentioned—abnormality ?

132. In case any of the urges 116 to 131 are existing in you,

(*a*) Are you able to explain them ? Do you think that you have been seduced into them ? Or did anything else prompt you to them ?

(*b*) When and on what occasion did you discover a particular urge ?

(*c*) Did you ever act according to your abnormal urge ?

133. Did you struggle against your nature ? By what means and with what success ? Did you ask a doctor, did get any treatment, from whom and with what results ?

134. Do you feel very unhappy ? Have you been fed up with life and did you attempt suicide ? Have you had troubles with your family with the officials or otherwise ? Blackmailing ? Did your urges ever bring you in trouble with the law ? Or with your own social and religious ideas ? In what position do you sleep ?

135. What do you think about your own sexual condition ? Do you feel guilty or free and easy ? Do you feel sick or healthy ? If possible, would you wish to have your present sexual condition changed ?

136. What did you experience with other people as far as sexual feelings or abnormalities are concerned ? Are you often together with people of the same feelings or are you often alone ? Do you know people who feel like you and about how many and through what causes ? Did you notice your feelings or abnormalities particularly with certain nations or people of certain social standing ?

137. Have you any opinion about the natural purpose of your sexual feelings ? What ?

If possible please write now :

(*a*) Exact reasons why you come to us ?

(*b*) Coherent description of your life ?

(*c*) Description of your sexual and love-life up to the present.

(*d*) If you had a chance to lead the life you like to, what would you do ?

Date when you have completed answering these questions.

Gastro-Duodenal Ulcers

By B. V. MULAY, M. S., Bombay.

This treatise is entirely based on the data I have obtained in personal experience during the last 14 years and I have avoided comparing my findings or mixing them in any other way with those found in standard surgical books. If I happen to differ in views or findings I do not in any way presume to expect that my views should be taken with any weight or authority. I have operated upon 185 cases for Gastro-duodenal Ulcer and roughly I have examined four times this number, which needed operative treatment for cure of the complaint. The views expressed here are the outcome of personal experience, which I must admit is limited.

AETIOLOGY.—Gastro-duodenal ulcers are more common in rural populations than in urban. (154 in rural and 31 in urban). It is more common amongst the poor than among the upper classes (167 : 18). It is oftener found in the males than in the females (147 : 38). It is more frequent between 20 and 40 and in my series there was not a single case below 17. It is more common amongst the Hindus than amongst the Mahomedans (174 : 11 *i. e.* 6%) while the Mahomedan population in the District and surrounding is more than 12%. It is more common amongst the vegetarians than amongst those taking mixed diet. It is not often found amongst those addicted to alcohol. The class of people from which 90% of these cases came is one, whose food from day to day through out the year, consists of Jawari bread and a paste of chillies. This is the class to which the labourer and farmer of Sholapur and surrounding districts belong. Diet appears to be a great factor. Amongst those who can afford to have vegetables, milk and its preparations, flesh with animal fat, rice and wheat, this disease is less frequent. Poor people on our side of the country—Sholapur, Bijapur and surrounding Nizam Territory—have to use chillies profusely to produce lubricating saliva to soften bolus of dry bread, before it can be forced down the gullet. Most of them have not the luck of tasting milk or ghee or any other kind of food for months. The mucous membrane of the stomach or duodenum is constantly in touch with this irritant condiment *viz.*, chillies for about fifteen hours in a day—counting 3 meals a day and 5 hours for each meal to make a complete exit out of the stomach and duodenum. The mucous membrane undergoes a chronic inflammation especially at the pyloric end, where the peptic glands, whipped constantly into great activity by stimulating chillies, make the gastric chyme highly acid. The mucous membrane gets into a state of chronic inflammation, becomes devitalised and very vulnerable to other damaging factors.

The second factor which comes into play in lowering the vitality of the mucous membrane, is pyorrhoea alveolaris. I have found pyorrhoea of varying degrees in nearly 70% of cases. The pus from the gums is constantly swallowed into the stomach and its contact with the mucous membrane of the stomach makes it unhealthy.

It is impossible to say definitely how a gastric or duodenal ulcer begins. But I subscribe to the view that it is generally produced by the absorption of micro-organisms into a small venule or lymphatic of the inflamed gastric or duodenal mucous membrane, producing clotting or thrombosis, which ultimately breaking down forms an ulcer. Once the surface of the mucous membrane is broken, with the mucous membrane devitalised by the chronic inflammation produced by chillies and by pyorrhoeal discharge, the hydrochloric acid and pepsin from the pyloric glands continue the process of extension of the ulcer by dissolving the tissue exposed at the bottom of the ulcer. The ulcer gradually increases in area and depth and as the stomach contents are acid, the ulcer gets no chance of healing, unless medical treatment and change in diet are prescribed. An ulcer of more than 6 months' duration rarely heals by palliative treatment.

Acute gastric ulcer is a rare phenomenon on this side and perforation and haemorrhage from

the gastric ulcer also quite as rare. I have so far operated upon only two cases of perforating gastric ulcers.

In the statistics of European countries gastric ulcer finds more incidence in the female sex, in whom also perforating ulcers are very often found.

It is probable that absorption from septic foci elsewhere in the body is responsible for certain percentage of gastro-duodenal ulcers. The appendix is considered as a chief offender in this respect, but in all my cases operated upon, I have not found more than half a dozen cases where appendix was required to be removed owing to involvement in inflammatory process.

SIGNS AND SYMPTOMS.—Acute gastric ulcer is rarely found in our part of the country and the signs and symptoms I describe are those found in chronic gastric or duodenal ulcer.

The first classical symptom in my observation is pain following food, in the epigastric region over the pyloric point, accompanied by signs of indigestion *viz.*, burning in the chest, feeling of heaviness in the stomach producing lassitude in the whole body, loss of appetite and constipation. In the beginning the pain recurs daily for a few days and is then followed by a quiet interval, varying from a few days to weeks. This is followed by periods of pain and quietude alternately and thus the cycle goes on until by gradual decrease of the quiet period the pain becomes a daily constant visitor. In the case of gastric ulcer the pain starts about half to one hour after food and 3 to 4 hours in the case of duodenal ulcers and stops completely when the stomach is emptied either in natural process or by vomiting. When the disease is much advanced pain sometimes persists even when the stomach is empty and is aggravated by intake of food. In duodenal ulcer, pain in the stomach is stopped by a fresh intake of food and is known as hunger pain. In the case of duodenal ulcers pain begins after 3 hours, when the acid chyme starts passing into the duodenum.

The second classical sign is tenderness over the pyloric point, which is placed midway between the ensiform cartilage and the umbilicus and slightly to the right of the middle line. In a few cases the tenderness is found on the left of the middle line. The tenderness becomes more marked, when pain appears and remains in evidence as long as the stomach is not emptied.

The third classical sign is gurgling in the stomach near the pyloric area. In the intelligent classes the disease should not be allowed to progress to the stage when gurgling occurs. All gastric ulcers on account of their insidious beginning are treated first by the victims themselves and then by medical men as ordinary indigestion and in 50% of cases the victims come with the diagnosis, phonetically declared from the abdomen, especially when the patient is seen after food. This is the stage of the beginning of organic stenosis, with a factor of spasm in the pylorus and the gurgling which depends for its loudness on the degree of stenosis and is produced while the chyme mixed with air is forced through the contracted pyloric orifice.

The fourth classical symptom is visible peristalsis of the stomach which begins on the left at the cardiac end of the stomach and terminates at the pyloric orifice in a wave and as each wave subsides, another heaves up on the left. The pylorus in the healthy man is closed while the stomach is empty. After food the gastric juices carry on the digestive process and when chyme is formed, the pylorus opens at intervals and gradually allows the stomach centents to be emptied at short intervals into the duodenum. The stomach completely delivers its charge of food in about four hours. When ulceration occurs at the pylorus, the pyloric sphincter is affected by spasm owing to the pain caused by acid chyme passing over the raw surface of the ulcer and a sort of functional stenosis occurs, setting up an obstruction to the passage of food. The obstruction naturally calls forth more effort on the part of the muscle of the stomach to overcome it. The effort causes more thickening of the gastric wall. During the stage of organic obstruction these processes increase much more,

the stomach wall becomes thicker and thicker and yet it cannot efficiently cope with the work of emptying the stomach within the specified time, resulting in gradual dilatation of the stomach. At this stage the stomach content which is normally not visible on the abdominal surface, is evident to the eye in the epigastric region and becomes more prominent after food. When strong peristalsis starts in about 2 or 3 hours after food, the stomach content can be seen on the surface of the abdomen above the umbilicus in the form of waves from the left to the right. The direction of this wave is diagnostic of stenosis of the stomach or duodenum. In the case of obstruction of colon at or below the splenic flexure, the direction of the peristaltic wave is from right to left and in the case of obstruction at or above the iliocaecal valve, the peristaltic waves in the ilium are seen round about or below the umbilicus.

In some long standing cases, the dilatation of the stomach reaches the pelvis and in these cases the peristaltic waves are seen below the umbilicus but the direction of the waves remains essentially the same from the left starting in the left epigastric region and proceeding downwards and to the right around the left side of the umbilicus, turns upwards and to the right, ending on the right of the umbilicus. In these extreme dilatations the constant peristalsis in the huge stomach sac and its weight actually pulls down the first part of the duodenum and the pyloric point is shifted downwards, lying just above and to the right of the umbilicus.

The fifth classical symptom is pain at the back to the right of the spine about the eleventh and twelfth thoracic vertebrae. This symptom is present in nearly 60% of cases. The pain is of a dragging type, appearing when the stomach becomes heavy with food and is due to adhesions of the pylorus or duodenum with the posterior wall of the abdomen. It is often found that when the pain is very severe, the patient uses a pad of pressure or manual massage on the back at the site of pain to obtain relief.

Vomiting.—This is described by European authors as one of the three classical symptoms of gastro-duodenal ulcers *viz.*, pain, vomiting, haematemesis. In my observation this is not a prominent symptom in the early stages of the ulcers. In my series of 185 cases it was a symptom in 25 cases in the early stages, in 38 cases in the later stages, in 41 cases as a voluntary deliberate effort of emptying the stomach by the use of fingers in the throat, resorted to by the patient, as it gave relief to the discomfort in the stomach loaded with food. In the remaining cases it was a rare occurrence.

Haematemesis.—In not more than a dozen cases I have seen so far, did I find history of vomiting blood. It is quite true, that the microscopic or chemical test will prove its presence in the vomited matters but visible blood is very rare.

Splashing sound in the stomach.—The mucous membrane of the dilated stomach becomes congested and unhealthy and when the stomach takes very long to empty, some putrefaction occurs producing gas in the stomach. The stomach wall although hypertrophied has not the same healthy tone of a normal stomach and becomes lax even when occupied by food, unlike the normal stomach which efficiently contracts over the full stomach. Owing to the laxity of the gastric muscles a splashing sound is produced when the body is moved briskly in the lying down position, from side to side, by the movement of the fluid chyme in the gasy stomach. In advanced cases when the stomach does not get emptied for a very long time, this symptom can be elicited in the morning before the patient has had any fresh intake of food.

Tumour.—A distinct tumour is in rare cases palpable at the pyloric site and this could be diagnosed from cancer of the stomach by examination of the stomach contents.

COMPLICATIONS.—I have come across only three complications in my series. Carcinoma of the pylorus in long standing cases in patients above 40 was found in four out of 185 patients. Perforation was seen in two cases and hour glass stomach was observed in one case.

Looking to the large percentage of long

standing cases, that I came across at Sholapur varying in duration from 3 months to 15 years, the majority being 2 to 3 years, it is very surprising that complications such as perforations, bleeding, gastric fistulae and carcinomatous changes are so rare.

DIAGNOSIS.—In a large majority of cases there should not be much difficulty in arriving at a correct diagnosis. Pain in the epigastrium after food, earlier in pyloric and later in duodenal ulcers, tenderness on the pyloric spot, complete relief of pain when vomiting occurs, gurgling at the pyloric spot 3 to 4 hours after food, make up a definite picture of gastric or duodenal ulcer. In the case of duodenal ulcers the pain after food is stopped for a time by a fresh intake of food. This pain being known as the typical hunger pain. In the later stages when stenosis occurs either spasmodic or organic, diagnosis is made more clear by the peristaltic waves in the stomach wall which are very often visible on the surface of the abdomen. When the patient is examined after food lying supine, a definite roundish elevation occupies the epigastrium more on the left side. Tapping over the elevation with the fingers, produces a more marked prominence and if you keep on watching the epigastric elevation with patience, tapping at intervals, a wave will be pronounced running from the elevation towards the right side of the abdomen. Whenever a strong wave comes out, gurgling is heard at the pyloric spot at the termination of the wave.

The skiagrams give definite help even in early cases to arrive at a correct diagnosis.

DIFFERENTIAL DIAGNOSIS.—Gastro-duodenal ulcers have to be differentiated from the following conditions,—gallstones, chronic chlolecystitis, cancer of the stomach, atonia of the stomach, gastroptosis and chronic appendicitis, tuberculous disease of the stomach and tuberculous disease of the pyloric lymphatic glands.

Gallstones.—The pain in gallstone has no relation to food, pain is constant and in cases where adhesions occur between the gallbladder and the pylorus, it is increased by food but is not completely relieved after vomiting. Tenderness is shifted more to the right lying opposite the tenth rib on the costal margin. Gurgling and peristalsis of the stomach, evident as signs of stenosis of the pylorus or duodenum are absent.

Cholecystitis.—In this affection the pain comes in periods. In the stage of inflammation the cystic duct gets temporarily closed, the gallbladder enlarges and becomes tense, giving rise to a constant dull pain and is felt as a small rounded tumour below the costal margin at the tenth rib.

Cancer of the pylorus or duodenum has a history of rapid progress in a patient advanced in age and the general system suffers out of all proportion compared to the wastage found in ulcers. Pain is constant, increased by food and not relieved completely after vomit. Tenderness is more marked and the tumour is felt at the pyloric spot. Chemical examination of a test-meal confirms the diagnosis of malignant tumour.

Atonia of the stomach is a result of long-standing indigestion in which the stomach is abnormally roomy and the musculature functionally weak. Food remains too long in the stomach, leading to formation of gases and the stomach gradually becomes more dilated. There is a feeling of discomfort and heaviness after food, a constant trouble of eructations after food. Although stomach content is prominent after food on the abdominal surface, no peristaltic waves are seen.

Gastroptosis is accompanied by ptosis of the intestines, liver and spleen. The abdomen below the umbilicus is prominent. A dragging pain is present along the costal margin and back. There is no tenderness on the pyloric spot and vomiting is absent. Displacement of the liver and spleen downwards gives an indication of the nature of the trouble.

Tuberculous disease of the stomach is rare. I have operated upon 3 cases so far. In two of them there was a ring of tubercles around the stomach near the pyloric end from one curvature to the other on both surfaces and a contraction of the ring had produced stenosis. The proxi-

mal portion of the stomach was dilated and hypertrophied. A few glands were observed on the greater curvature which were removed and on section showed the typical formation of tubercles. Gastro-jejunostomy gave complete relief. The third case was different from these two. The pyloric and the right epiploic glands were involved in tubercular enlargement and forming into a large lump had pressed on the pylorus to such an extent that the tumour produced constrictions of the pylorus obstructing the passage of food into the duodenum. All the symptoms of gastric ulcer were present in these cases and the only symptom that gave rise to a suspicion of the real nature of the trouble—after the first experience—was temperature of hectic type.

Fibrosis of the Stomach.—This is a rare affection and was found in two of my cases. The stomach wall becomes exceedingly thickened and loses its elasticity and the cavity in the stomach is reduced to a diameter of about an inch and a half to two inches. Owing to the stiffness in the wall caused by the replacement of the gastric muscles with fibrous tissue the cavity does not admit the proper quantity of food. Vomiting immediately after food is a prominent sign. The chief point of differentiation is the very small amount of food that can be admitted into the stomach and which is not retained long. Rapid wasting occurs and no peristaltic waves of the stomach wall are seen on the abdomen.

PROGNOSIS.—There is a fair chance of cure with medical treatment in the early stages, within the first six months of the life of the ulcer. Later on cure is rare except by surgical interference. It is not possible to state what percentage of gastric ulcers end disastrously by perforation or haemorrhage, as statistical records in India do not exist even to-day, from which conclusions can be drawn. It is, however, quite safe to say that fatalities in gastric ulcers by perforation or haemorrhage, are not at all so commonly found in our part of the country as they are found in Europe. When the ulcer becomes chronic, the victims generally find out the dietary and medicine (sodium bicarbonate), which allay the pain and soothe the stomach. Such victims carry on with the trouble for years, until they are carried away generally by other diseases or until they get tired of the unhappy life and give up themselves into the hands of the surgeon.

Prognosis of a cure after operation is very bright and the relief is immediate and marked. Patients, who used to get sick at sight of food before operation yearn for it a few days after operation and can take solid food within ten days. As soon as the stomach is short-circuited, the chyme no longer keeps up the irritation of the ulcer, which heals quickly.

TREATMENT.—Palliative treatment consists of using a dietary that wlll not give rise to copious secretions of hydrochloric acid and pepsin and which will take less time for gastric digestion and of exhibiting drugs which will keep the gastric contents alkaline.

The best way is to keep the patient on milk, sour milk, fruits, a few potatoes and green vegetables. Stomach should be kept alkaline by means of sodium bicarbonate, magnesium carbonate and bismuth carbonate. In the cases of acute pain hydrocyanic acid dilute and tincture of opium are very useful. After pain completely subsides and tenderness is gone, solid food by way of bread and butter, small quantity of rice and ghee should be allowed. Pulses should be avoided for a longer time. Meat diet and eggs should be avoided for a few months. A thorough trial with palliative treatment for 3 or 4 months should settle the question whether cure is possible without operation and if no relief is obtained at the end of this period it is advisable not to waste time and sacrifice patient's health and working capacity by postponing surgical treatment.

Preparation of patient for operation.—Most of my patients with gastric or duodenal ulcers come from the poorer classes in the villages. It is not found necessary to give them any special preparatory treatment before the operation except when the stomach is much

dilated. These patients from moffusil although far from being properly nourished and healthy owing to poverty, have a peculiar stamina in fighting against surgical shock, compared to patients from the urban areas. I have actually found that if those poor patients be placed in the hospital on milk diet for some time before operation, they do not stand the operative shock so well as those who are taken up immediately on arrival, for operation. On the day before operation, a purgative is given and the patient put on milk and sour milk, ghee and sugar and fruits. In the evening before the day of operation his stomach is washed, an enema is given and the abdominal surface cleaned for operation. At night he is given sugar and water. If the operation be undertaken in the morning before 10 A. M. the stomach is kept empty and in case it is taken up after 10, sugar and water are given at 7 A. M.

Operation.—I do not think it necessary to describe in detail the operation usually done, which is posterior gastro-jejunostomy. In performing anastomosis I use silk number 1 for sero-muscular suture and iodine catgut number zero for the through and through inner suture. Both sutures are continuous. The silk suture is first put in half way from left to right and is left there for the time being. After the incisions are made in the stomach and jejunum, the through and through catgut suture is first loosely put in loops from right to left through the contiguous lips of the incisions in the stomach and jejunum, forming the posterior half of the inner suture and then each loop is successively tightened. On reaching the left angle of the anastomosis the catgut thread is handed over to the assistant, who holds it sufficiently tense. The catgut suture is then carried forward through the anterior edges of the incisions in the stomach and jejunum in the fashion of loop on mucosa, until the starting point of the catgut suture is reached, the loops remaining loose. The clamps on the stomach and jejunum are loosened or removed and anterior row of catgut loops tightened, the free ends being tied in a knot. The silk suture, which is left half done is then carried forward from right to left angle of the anastomosis, where it is knotted with the other free end. The anterior edge of the aperture in the mesocolon is sutured to the stomach wall near the line of anastomosis. The abdominal wall is repaired with through and through silk-worm gut sutures. I do not give morphia either before or after the operation and, the anaesthetic used is chloroform, administered with a Junker's apparatus.

Post operative treatment.—Rectal saline is given 4 ozs. every four hours. The patient is encouraged to turn on sides two hours after he comes round. He is allowed to gargle water after 6 hours and is given sips of water to drink after ten hours. Water is freely allowed after 24 hours and then rectal saline is stopped. Sugar is given along with water 3 or 4 times on the second day. An enema is given on the second day and repeated twice a day until liquid motion coloured with bile is produced. If an enema does not succeed within 36 hours it is aided by an injection of pituitrin. On the third day fruit juice and sugar are allowed and milk and soda in equal parts are given from the fourth day. If everything goes on allright rice is allowed after a week and Jawari bread after two weeks. The wound is dressed twice a week and sutures removed on the fifteenth day.

Post operdtive complications.—

(1) *Vomiting of bile* is found in about 40% of cases about 12 hours after operation which is relieved by washing the stomach with a solution of sodium bicarbonate. In a few cases the stomach has to be washed more then once. Vomiting entirely stops after dark coloured bile appears as the results of an enema.

(2) *Paralysis of the bowel* occurs to a slight extent temporarily in every case and until an enema is given flatus is usually not passed but this degree of bowel paralysis does not cause tympanitis. When tympanitis is very troublesome injections of pituitrin and repeated enemas bring about the movement in the bowels.

(3) *Haematemesis* is a rare complication and may be so severe as to cause death. I lost two cases in this way and in one of them on a

post-mortem examination, I found the sutures firm and efficient but the bleeding came from the base of the ulcer.

(4) *Hypostatic Pneumonia* is a serious complication and liable to produce a fatal issue in a patient run down by long suffering.

(5) *Recurrent vomiting* was found in two cases and repeated washing of the stomach was successful in one case while the other succumbed after 15 days.

(6) *Intestinal obstruction.*—If the aperture in the mesocolon is not closed by suturing its edges to the stomach wall, the intestines are liable to pass through it into the lesser sac of the peritoneum where they become strangulated. If the lips of the aperture in the mesocolon is properly sutured this complication should not arise.

(7) *Ulceration of the suture line and stitch abscess.*—In cases of post operative lung trouble, attended with much cough, the strain of coughing on the sutures produces ulcerations of the suture line and stitch abscess. In such cases the wound should be dressed daily with hydrogen peroxide and dusted with anti-septic powders. After ten days we should start removing sutures one by one as it gets loose.

MORTALITY.—The average mortality in my cases from the beginning so far is 8% and in the last 39 cases there was no fatality.*

* Paper read at the VII All-India Medical Conference, Poona.

Mistakes In Diagnosis and Their Causes

By Khan Bahadur E. S. BHARUCHA, L.M. & S., F.C.P.S., B.M.S. (Retd.)

It is an established fact that a correct diagnosis forms an essential condition for the successful treatment of diseases. The science of diagnosis has advanced so considerably during the past thirty or forty years that many cases which otherwise before remained undiagnosed and therefore probably untreated or wrongly treated are now capable of being treated with great success. The various new methods for diagnosis that have come into general use during the past forty years of my professional experience have essentially revolutionised the science of diagnosis—though still in many cases it remains imperfect. In those days, beyond the use of the clinical thermometer, the stethoscope, chemical examination of urine and the occasional use of the aspirator, there were no other methods of coming to a definite conclusion regarding the nature of the disease in a particular case than its history, its course and progress. The examination of blood, sputum, faeces etc. was then unknown or scarcely carried out, the valuable information which a physician can now get with the X'rays was not even heard of, the sphygmomanometer was still non-existent as one of the essential instruments for diagnosis and the only confirmatory evidence of a correct or incorrect diagnosis was in not a few cases obtained during the post-mortem examination. Yet with all the advance in the science even in present times there are numerous cases which even the most experienced physicians are incapable of correctly understanding. Mistakes in diagnosis are indeed frequent, in some cases too frequent. If only all of them were published instead of correct diagnosis as is the rule at present with many, it would be readily admitted to be of immense benefit to all. Nothing could be more instructive than a mistaken diagnosis recognised, analysed and reflected upon. Indeed, its value would in some cases at least be greater than many a correct diagnosis. A writer has stated that a publication of all mistaken diagnosis with their causes would prove of the utmost service—a proposition which will be readily accepted by all true lovers of the science.

Before proceeding with the causes that give rise to mistakes in diagnosis it would be well first to consider what is meant by correct diagnosis. Such a diagnosis must be complete and not merely labelling a case with the name of a disease such as Pneumonia, Valvular affection of the heart,

Nephritis and so on. This is only partial diagnosis, a mere clinical symptom and would be of little or no avail in the proper line of treatment. A complete and satisfactory diagnosis should consist of (a) clinical diagnosis obtainable from subjective and objective symptoms presented by a case, (b) a lesional diagnosis giving the seat and structural alteration in a case, otherwise called pathological diagnosis, (c) functional diagnosis giving the functional disturbances in a case—otherwise called physiological diagnosis and which is most important, (d) etiological diagnosis giving the specific cause of the disease in a given case. As an example, let us take a case of acute lobar pneumonia. The pain, high fever, cough, rusty sputum would consist of the clinical diagnosis, the consolidation of one or both lungs or a part of them, the lesional or pathological part of the diagnosis, the dyspnoea, the physiological or functional part of the diagnosis and lastly the specific organism—pneumococcus, FRIEDLAENDER'S bacillus, influenza bacillus etc., the etiological part of the diagnosis.

By a careful and systematic examination of a particular case it would not be difficult to arrive at a complete and satisfactory diagnosis in many cases. Such, however, is not the case with all diseases. In a number of them the etiological factor is found wanting *e. g.* in the several varieties of neuroses. In others the pathological lesion is not available even after a very careful post-mortem examination, as in some cases of epilepsy. This is particularly the case with almost all skin affections in which beyond the visible clinical symptoms no other factor is available. No wonder, therefore, dermatology is one branch of the science of medicine in which treatment is still very unsatisfactory.

Before proceeding with the consideration of the causes of mistakes in diagnosis I would here give a few instances of some mistakes of my own in my practice which will give you some idea of the subject.

Two cases that passed through my hands as a clinical student during my college days have left a permanent impression on my mind. The first was a case of acute pneumonia diagnosed by me as double pneumonia (consolidation of the whole of the right lung and the base of the left). This diagnosis was accepted as correct by my professor. On post-mortem the right lung was found typically pneumonic throughout as expected, but the left was merely in a state of congestion and the spleen was found considerably enlarged upwards, pressing and almost squeezing the base of the left lung. The dull note of consolidation (?) found during life was that due to the enlarged spleen.

The second was a case diagnosed by me as acute pneumonia affecting the base of the right lung which diagnosis was also accepted as correct by my professor. Two or three days after, the patient had a violent fit of coughing during the night and the next morning he was found expectorating typical hepatic pus. Both these cases taught me a lesson which I need hardly say proved to be of immense value to me in my practice in after life, *viz.*, to always examine the dimensions of the liver and spleen in suspected consolidation of the base of the lung.

Two cases of acute uncontrollable vomiting, the cause of which could not be ascertained, are of interest. The first came under my treatment when I was still a very junior practitioner. The patient was a middle-aged gentleman who for more than a fortnight was unable to retain any food or drink in spite of treatment. Consultation with an experienced physician in Bombay was of no avail, until one morning the patient vomited a round-worm, after which he became rapidly convalescent. This has taught me a lesson not to forget the possibility of intestinal parasites in the stomach in any doubtful case.

The second case was that of a middle-aged widow who had uncontrollable vomiting with headache for two or three days. The case not improving under the usual treatment was therefore taken by me to the hospital, and a complete medical examination revealed to me that she was suffering from acute nephritis. About a week after the finding of the diagnosis she had violent uraemic convulsions and the case ended fatally. I have often asked myself whether the life

could have been saved if the kidney condition was diagnosed earlier.

Next I would give here a short history of two cases of ascitis. The first was that of a dying old woman admitted in my ward at the Sassoon Hospitals as a case of ascitis needing immediate paracentesis. I found her, however, in a practically pulseless condition and therefore postponed the operation and she was kept on stimulants. She lived a few hours, and the next morning on post-mortem, it was found to be a case of diffuse purulent peritonitis, resulting from the bursting of an hepatic abscess. I may here state that in my practice this is the only instance of hepatic abscess bursting in the peritoneum met with by me and but for the post-mortem it would have gone unrecognised.

The second was also sent from the Externe as an urgent case requiring paracentesis owing to great swelling of the abdomen and consequent dyspnoea. The externe diagnosis was taken for granted, and paracentesis was performed. The fluid was found to be quite unlike ascitic and typical of ovarian cyst. The operation was immediately stopped, and two or three days after a huge cyst was removed. Moral—in no case should a diagnosis done by another person, however competent, be taken for granted but should be personally verified by the usual methods.

At one time we had a series of five or six cases of intestinal obstruction admitted in our ward within a few days of each other, suggesting almost an epidemic of that complaint. In those days abdominal surgery was not so freely in vogue and only selected cases were submitted to operations. As a result the nature and causation of the cases remained unknown until in one case on post-mortem it was found to be due to a very small strangulated inguinal hernia for which there was no indication during life. This however proved to be a hard-earned lesson and ever since in all such cases the possibility of a strangulated hernia has been kept in my mind prominently for investigation.

I do not know if any of you have come across cases of pregnancy remaining undiagnosed till late or *vice versa*, abdominal tumours from other cases being taken for pregnancy. PLAYFAIR and other authors mention these mistakes to have occurred in the hands of the most experienced accoucheurs. In my student days a case was diagnosed as a fair-sized ovarian cyst and was placed on the table for its removal. After incision to the surprise of all it was found to be a case of pregnancy in the fourth or fifth month. I had a case of a middle aged lady about 42, married for over 20 years who had no children. An experienced gynæcologist had told her she would never become pregnant. She had an abdominal tumour about the size of a four or five months pregnant uterus. I was considerably puzzled especially after the history given as to its nature, though it was not inconsistent with the possibility of its being due to pregnancy. On consultation, however, I was advised it was a case of ovarian cyst and an operation was suggested. Fortunately, the patient was not willing to get it done, nor was there any urgency for it. So she remained under my observation and about five months after I had the satisfaction of confining her of a baby which unfortunately for the lady lived only a short time after birth.

I would give one more instance of mistaken diagnosis which came under my observation a couple of years back before proceeding to discuss its causes. This was the case of a young primipara with obstinate vomiting. She was examined in Ahmedabad by a very experienced lady doctor before she came here and when I saw her, beyond the obstinate vomiting, there were no other symptoms. I do not know why but I suspected it to be a possible case of tubal pregnancy and therefore had a consultation. I was assured that it was not so and that in time the vomiting would stop. The patient gradually got better but used to get paroxysms of vomiting every now and then which continued throughout the whole period of gestation. She was in due course admitted in the Sassoon Hospitals for labor and as it did not progress satisfactorily, making no impression on the cervix a caesarean section was performed and to the surprise of all a

healthy living full grown child was extracted from the right fallopian tube. This is a rare instance of tubal pregnancy ever going to term. Both the mother and the child are now alive and well.

Mistaken diagnosis, it will be seen from the cases cited above, can arise from various causes. They may be either due to (*a*) ignorance, or (*b*) hasty, imperfect and faulty examination, or (*c*) to errors of judgment.

(*a*) Those due to ignorance necessarily will be few and far between as it is expected all qualified persons possess a fair up-to-date knowledge of the profession. Such as would occur will then be due to ignorance of recent clinical advances or in some cases to the rarity of certain diseased conditions such as the case of tubal pregnancy mentioned above. Progress in laboratory, X'ray and other methods of clinical investigation is now so rapid that it would be excusable for even established physicians to be unacquainted with all new discoveries. Unfortunately one is so flooded with new ideas and new methods of examination and treatment in these days that it is difficult to separate doubtful or even useless methods from really useful ones. In all such cases one has to take the assistance of specialists in their own line of work. Then again certain clinical conditions are so rare that a practitioner may be readily excused for not spotting them, he not having had occasion to come across them *e. g.* congenital pyloric stenosis, psittacosis etc. Further we must not forget that a certain number of cases are essentially undiagnosable and no amount of care and thorough investigation could prevent the mistake, as for instance amyloid liver, hydatid cyst of the kidney, aneurysm of the heart. At least such conditions could only be guessed sometimes correctly more often wrongly. Lastly every body knows that there are numerous conditions which are still unknown and consequently undiagnosable as the large group of fevers of unknown origin.

(*b*) Mistakes most commonly found to occur in practice are due to hasty, imperfect and therefore faulty examination. The rule to give a thorough rapid overhauling in every case of all parts of the body should naturally tend to minimise such mistakes. Yet in actual practice one finds it so difficult to adhere strictly to that rule! Examination of patients in unfavourable circumstances is one of the difficulties. How often one comes across cases that have to be examined in bad light, or amongst awkward surroundings. Again certain patients either through fear, or preconceived notions, and not infrequently deliberate concealment of facts render it difficult for one to correctly investigate a case and thus tend to mislead the physician. With our ordinary hospital cases, to get a correct history is next to impossible—in fact, a physician has often to exercise a considerable amount of patience to extract any valuable information from them. Not infrequently one comes across patients who lead the physician astray through misinformation on purpose. This is specially the case with the history of syphilis as no doubt must be the experience of many. Then there are cases where on account of unconsciousness, or as in the case of children no reliable information is available. Lastly some of you must have come across obstinate patients who would not help you in any way "keeping the information they could give as if under lock and key." I have a fair experience of it myself causing me no little annoyance on some occasions and even amusement on others. To all these examples of imperfect investigation may here be added one more *viz.* want of time on the part of a busy practitioner. Comment on that subject is unnecessary.

(*c*) By far the greatest proportion of mistakes in diagnosis, however, result from errors of judgment. A correct and complete diagnosis can only be made by careful analysis of the data collected after a conscientious and thorough examination of a given case. However conscientious the physician may be, correct deductions will depend on his mental capacity and a vast knowledge of his profession. Some would come to a correct decision almost at sight and without any effort. Others on the contrary would have to exercise a great amount of thought and mental

strain and even then the conclusions arrived at may not be correct. Not a few cases of errors of judgment are due to what is described by an author as "obsession". This is specially the case with the so called "specialists". Their field of work is necessarily narrowed down to one particular diseased condition and they have a tendency to make everything fit into their restricted field. A general practitioner habituated to take an all round view of a case has necessarily a broader perception. The question of the presence or absence of tuberculosis in a case is an instance of the kind. I have come across several instances of mistakes of that kind in my practice, some of which have been committed by myself, others by my colleagues in practice. They may be due either to (a) denial of the presence of tuberculosis when suspected which ultimately proved positive and (b) putting down a case positively as one of tuberculosis which was not one of that fatal disease. Indeed I have come across a fair number of cases of so-called tuberculosis, completely cured, which to my mind were never real cases of that fatal disease. I shall illustrate my point with one or two instances in my practice.

A young man, the only son of a very dear friend of mine was being treated by a colleague for tuberculosis. He was shown to me at one stage of his complaint. I could detect nothing wrong in the lung. He had enlarged tonsils and a chronic cough without fever. I assured my friend the case was not one of tuberculosis and advised removal of tonsils which was carried out. The boy remained well for more than a year after when the cough returned, this time with fever and ultimately definite lesions appeared in the lungs which progressed rapidly and to my great sorrow the case ended fatally.

On the other hand I treated at one time a Mahomedan lady with frequent bouts of haemoptysis, the source of which could not be made out. Both the lungs were normal but the tonsils were enormously enlarged. On consultation I was assured it was a case of tubercle of the lungs. Some time after the haemoptysis subsided and I excised the tonsils. There was for a time considerable haemorrhage but it subsided under proper treatment and the lady made a good recovery and is still alive and well after nearly twenty years.

With the advance of technical procedures mistakes ought to be few and far between. At the same time the numerous technical procedures now in vogue are so superfluous that a practitioner would necessarily require to make a due selection out of those which are actually useful and indispensable for establishing an exact diagnosis. Abuse, however, of these procedures should necessarily be guarded against. Of what use for all practical purposes, say in a private patient—would be an X-ray examination in a case of mitral disease when the condition could be readily recognised in a couple of minutes by ordinary auscultation. Indeed the present day emphasis laid on the technical procedures in every case even at times to the neglect of the old well-tried clinical methods of examination is much to be deplored. It may be useful to have them carried out in a hospital, especially when attached to it is a teaching institution. But to my mind it becomes wasteful and to a poor patient unnecessarily burdensome when it is carried out in private practice. In most instances the usual clinical methods systematically carried out would prove quite sufficient and the laboratory and other methods of diagnosis should be kept as adjuncts for verification in doubtful cases. Devotion, experience, a thorough knowledge and above all the use of common-sense ought to in the end prove quite satisfactory to a practitioner. These when exercised by him in earnest would render him least liable to commit mistakes. *

* Paper read at the Scientific Section of the VII All-India Medical Conference held at Poona in April, 1931.

Method of Inducing General Anaesthesia by the Rectum and its Utility in General Surgical Practice

By G. B. POTDAR, L.C.P.S.

It is with feelings of considerable diffidence that I rise to address you this evening; the subject matter of the short paper which I am reading is of no little importance and usefulness to the medical profession, in view of the fact that it will, if judiciously practised, lessen in a large measure, the sufferings of the patients and also contribute to the easy and efficient performance of surgical operations in general.

The practice of surgery has been greatly facilitated by some means of abolishing pain caused thereby. It is only during the 18th century that any advance was made in this direction by SIR HUMPHREY DAVY in 1799, who anaesthetised patients during surgical work by nitrous-oxide gas. And the year 1847 saw the new era of chloroform anaesthesia. Operations undertaken after this year were great many in number and at the present day it is difficult to believe how surgical operations could ever have been undertaken without these agents.

You are aware, gentlemen, that the theme of my paper is "The method of inducing general anaesthesia by the colon and its utility in surgical practice". You will excuse me, therefore, if I go into the history of this.

Rectal etherization was first recommended by PIROGOFF in the year 1847. During the administration by this method abdominal distension occurred from unabsorbed ether, and this was found to irritate the large intestine and cause intestinal colic. This method, therefore, was suspended for some time, or was very sparingly used till in the year 1913, DR. JAMES T. WATHMEY improved the method greatly and called his method "Oil-ether-anaesthesia by the rectum". Since then it is known by various names as Rectal Anaesthesia, Colonic ether Anaesthesia and so on.

Let me at the outset say that we might encounter a little opposition from the patient, when we begin to administer the anaesthesia, but I need hardly point out to you, that in thus seeking the lower regions, we shall only, so to say, be stooping to conquer.

The mixture used consists of 4 ounces of olive oil, 2 ounces of ether and 2 drams of paraldehyde. One ounce is given for each 20 pounds of the patient's body-weight, but not more than 8 ounces in all.

It was first tried in the Sassoon Hospitals in the year 1928 on a case of cancer of the tongue, and when it proved a great success, we had no hesitation in giving the same kind of anaesthesia whenever it was indicated. It is due to the kind and encouraging instructions that DR. T. L. CHIPALONKAR, the Honorary Surgeon of the Sassoon Hospitals, gave me at the time of inducing the anaesthesia, that I have been able to say something on this subject today. The mixture we used was 4 ounces of ether, 2 ounces of olive oil and 2 drams of paraldehyde.

I should like at this stage, to say a few words about the preparation of the patient for the anaesthetic.

The patient is given a cathartic over night and nothing allowed by mouth. Early the next morning the bowel is washed with warm water till the fluid comes out quite clear. The rectum is then anaesthetised by injecting 10 grains of chloretone in ether and olive oil, or a chloretone bougie is inserted. About half an hour before the operation, some people advise an injection of one-fourth grain of morphia with atropine, but, this, I think may safely be omitted.

The patient is then taken to the anaesthetic room, and made to lie there quiet. The room should be free from all kinds of noise and must be more or less dark. When the operation is about 20 minutes ahead, a sterilized

rectal tube or a rubber catheter size 8 should be passed into the rectum. The pelvis is slightly raised on a pillow, and the mixture well stirred, should be poured in with a funnel from a height of about a foot and a half or two feet. The process of pouring in the mixture must necessarily be very slow and given, say at the rate of an ounce per minute. Given at this rate, the patient is unconscious in 5 or 6 minutes and is completely under in 20 minutes from the injection. A thick cotton pad is kept at the anus and a 'T' shaped bandage tied.

The stage of excitement is brief and struggling is absent altogether, or if there is any, it is negligible.

When the patient is under, the respirations are very smooth and easy without any stertor and the eyelid reflexes are retained with contracted pupils. It is in this stage that the patient has to be kept throughout the operation. Often it happens that the anaesthesia is not complete and all that has to be done is to wring out a towel in hot water and hold it over the nose and mouth of the paitient. This sets matters right at once and it is very rarely that chloroform will have to be given to get him under.

Sometimes, he is very deeply under, which of course, a careful anaesthetist will at once make out and for this a little of the mixture will have to be taken out, through the rectal tube.

After the operation is finished, the surplus fluid is withdrawn from the rectum and again a bowel wash is given and the patient is then removed to his bed. The patient comes round after a very long time, say, five or six hours and till then a nurse has always to be in attendance to see that the jaw and tongue do not fall back and impede respiration.

This method has been highly recommended in plastic operations of the face, which take a long time and in other operations on face, tongue, nasopharynx, pharynx, mouth, larynx, trachea, thyroid and chest or in other words in cases in which, were anaesthesia given by inhalation, the operator and the anaesthetist would interfere with each other.

The first case that we tried gave us great hope and we were tempted to use the same anaesthesia in one more case of cancer of the tongue, and one of the glands in the neck. All these cases did wonderfully well.

Let me briefly tell you the advantages of this anaesthesia :

(i) The amount of ether used is very much smaller than by the inhalation methods.

(ii) It is especially useful in fat alcoholics who take chloroform or ether very badly by the inhalation method.

(iii) It does not cause any sense of suffocation.

(iv) The stage of excitement and struggling is absent.

(v) There is no salivation or secretion of mucus in the bronchial tubes.

(vi) The post-operative nausea and vomiting are not common as compared with inhalation anaesthesia.

(vii) A frightened patient can by this method be anaesthetised with ease and without his knowledge.

(viii) Above all, the surgeon and the anaesthetist are on opposite extremes of the patient and gives the surgeon the fullest view of the field of operation without any sort of inconvenience both to himself and to the anaesthetist.

The only disadvantage that I found is that the anaesthetist has to depend only on the respiration of the patient for his guidance as he is unable to see the conjunctival or other reflexes.

Another disadvantage, if I may call it so, is that the patient takes a long time to come round probably on account of the paraldehyde that is used in the mixture.

This sort of anaesthesia is contra-indicated in all pelvic operations, whenever there is irritation or inflammation of the intestines and in laparotomy.

And now let me bring these few and all too brief remarks to a close. I am aware that I have not been able to offer you any very original or novel ideas regarding my subject matter. But, I trust that I have not failed in giving you in broad outlines, and I must add inadequately the importance of this highly useful process. Having regard to the many advantages attending this process, it is difficult to understand as to why it should not be pressed into service on a much wider scale than is at present the case.

Nothing remains for me now, gentlemen, but to thank you warmly for the very patient and sympathetic hearing that you have given me. *

* Address delivered at the Scientific Section of the VII All-India Medical Conference held at Poona in April, 1931.

Observation on the actions and uses of Herpestis Monniera

N. O. Scrophularineae.

By DR. KARTICK CHANDRA BOSE, M.B., & DR. N. K. BOSE, M.B.

From Dr. Bose's Laboratory—Research Dept. Calcutta.

Herpestis monniera, which is commonly known in Bengal as "BRIHMI-SAK", contains a very powerful active principle, which is an alkaloid in nature.

Vern. Sans.—Brahmi. Hind.—Barambhi. Beng.—Brihmi-sak. Mar.—Nir-brami. Tam.—Nir-brami. Tel.—Sambrani-Chettu.

PARTS USED :—Whole plant, preferably the leaves.

HABITAT :—This creeping plant is found in marshy ground throughout India.

DESCRIPTION :—Marshy glabrous, often punctate herbs ; creeping, rather succulent ; branches 4-10 in. long, rooting at the joints. Leaves ½-¾ in. opposite, fleshy, sessile, obtuse, entire in the Indian plant, ovate-oblong ; nerves very obscure ; lower surface dotted. Peduncles usually longer than the leaves, and 2 bracteoled. Flowers pale blue, purple-veined, single on alternate, axillary stalks. Calyx ⅙-⅓ in. long, 5 parted, upper sepal ovate, Corolla cylindric, twice as long ; lobes and stamens subequal ; style linear, stigma capitate, 2-lobed capsule included, ovoid, acute.

CHEMICAL COMPOSITION :—Samples of the drug from different sources were analysed. It was found that all the specimens contain an alkaloid in varying proportions, rising to a maximum of about 0·04%. A sample of an allied drug known as "THALKURI" (Hydrocotyle Asiatica) was also examined. It was found that it does not contain any alkaloid.

The alkaloid is fully extracted when macerated with Ether-chloroform mixture in the cold. Rect. Spirit requires prolonged maceration for complete exhaustion.

Boiling water extracts only 0·01% of the alkaloid but when treated with boiling mixture of glycerol and water, 0·02% of the alkaloid is extracted.

Total alkaloid of :—

i. Brahmi leaves (dried) ... 0·05%
ii. „ stems (dried) ... 0·005%

TOXICITY OF THE ALKALOID :—

The alkaloid is highly toxic for lower animals, particularly in frogs where 0·5 mg. per 100 gramme body weight injected into the sublingual space kills the animals within a maximum period of 10 minutes. Rats and guinea-pigs require a higher dose, about 25 mg. per kilogramme body weight kills the animals within a maximum period of 24 hrs.

TOXIC EFFECTS OF THE ALKALOID :—

0·5 mg. per gramme body weight when injected in frogs produces strychnine-like convulsions immediately, and gradually there is paralysis of the hind limbs. Respiration fails first, but the heart continues beating very slowly and irregularly. It greatly depresses all the muscles of the body and the animal when placed on its back does not show any inclination to assume its normal position.

PHARMACOLOGICAL ACTIONS OF THE ALKALOID :—

(a) Blood pressure—0·5 mg. to 1 mg. per kilogramme body weight of anaesthetised cat produced fall of blood pressure followed by gradual recovery. This fall is solely due to stimulation of the vagus nerves, as it is absent after paralysis of the vagal nerve-endings with atropine. (Graphs I and II).

Smaller doses produce persistent rise of blood pressure (Graph III) and this rise in the blood pressure is due to two factors.

i. Vaso-constriction produced by the stimulation of the sympathetic nerve-endings.

ii. Stimulation of the cardiac muscles.

That the alkaloid stimulates the sympathetic nerve-endings is proved by the fact that the rise in blood-pressure is partially reduced after paralysis of these nerve-endings by Ergotoxine (Graph IV).

(b) Blood-Vessels—Perfusion of the frog's blood-vessels after LAEWEN-TRENDELENBURG'S method shows well-marked constriction in a dilution of 1 in 200,000 to 500,000.

Kidney volume shows a constriction but the vessels of the liver seem to dilate.

(c) Heart.—Perfusion of the frog's heart through the Inferior Vena Cava after HOWELL and COOK'S method shows marked increase in the force of contraction only with a dilution of 1 in 500,000 (Graph V). Any lower dilution immediately stops the action of the heart.

(d) Respiratory system.—The alkaloid stimulates the respiration through the parasympathetic nerve-endings, as this stimulation is absent after the paralysis of these nerve-endings with atropine (Graphs I and II).

(e) Gastro-Intestinal system.—The alkaloid stimulates the movements of the intestine and makes the movements regular in a dilution of 1 in 200,000 to 500,000 (Graphs VI and VII). Higher concentration relaxes the intestine.

(f) Uterine system.—The alkaloid has a marked effect on the uterine muscles whether the uterus is virgin, pregnant or multiparous and the effect is mainly muscular. (Graphs VIII, IX, X). A dilution of 1 in 200,000 to 500,000 produces marked contraction and there is relaxation of the muscles in a concentration of 1 in 100,000.

(g) Muscular system—In the nerve-muscle preparation the height of contraction is increased after the application of the alkaloid even in a dilution of 1 in 50,000 to 200,000 (Graphs XI and XII).

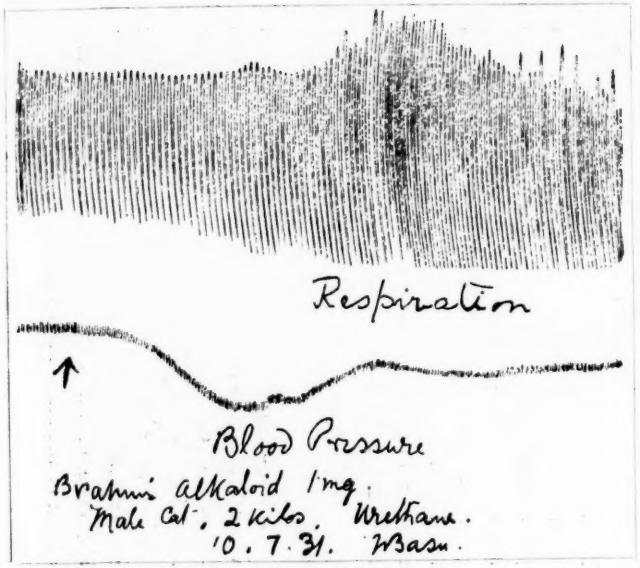
(h) 0·1 per cent solution of the alkaloid when put into the eye of the rabbit, does not produce any corneal anaesthesia.

(*i*) Injection of 1 per cent solution of the alkaloid into the subcutaneous tissues or into the muscles of the lower animals does not produce any inflammatory change in the tissues.

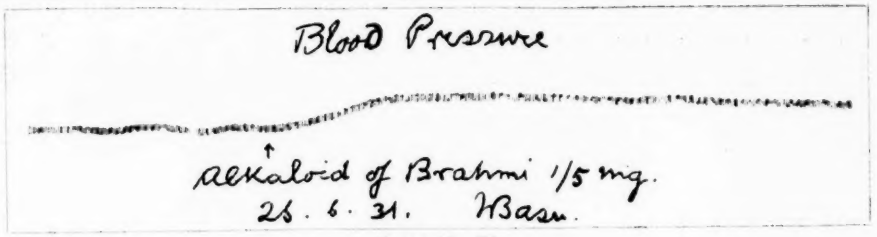
EFFECT OF THE WHOLE DRUG OF HERPESTIS MONNIERA

In order to test the effect of the whole drug, watery extract was prepared (1% sol.) and it was found to contain very small amount of the alkaloid.

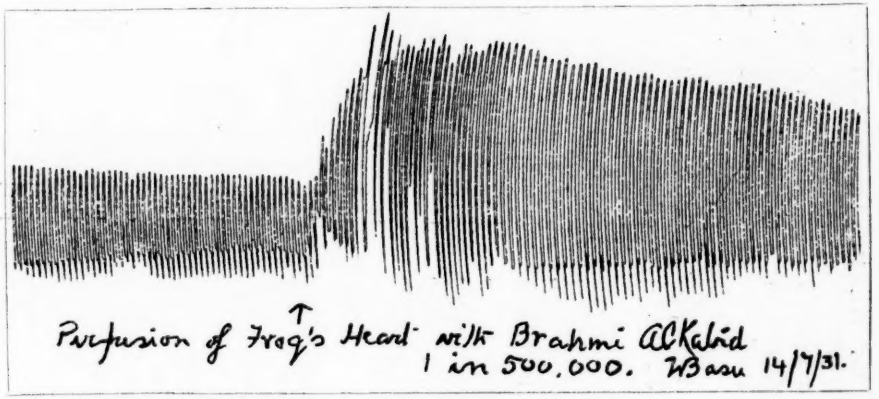
Pharmacological actions of the whole drug run parallel with the alkaloid and only with a very big dose of this watery extract could depressant action of the alkaloid be obtained.



Graph No. I.



Graph No. III.



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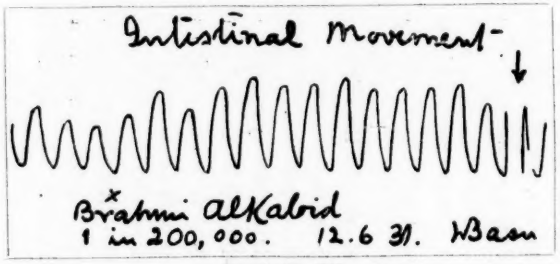
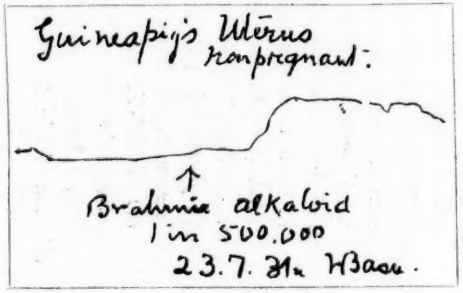
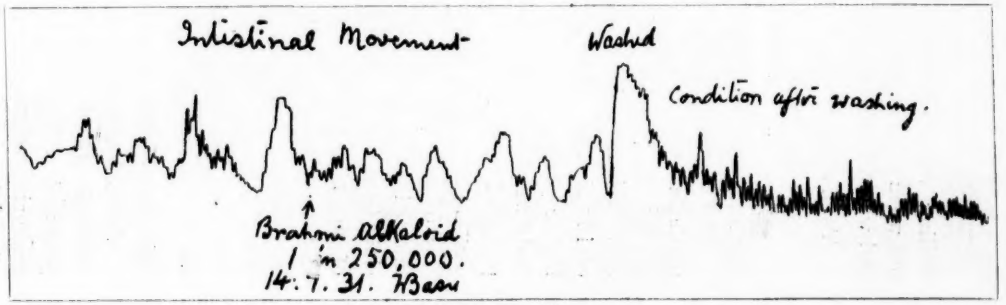


Graph No. VI.



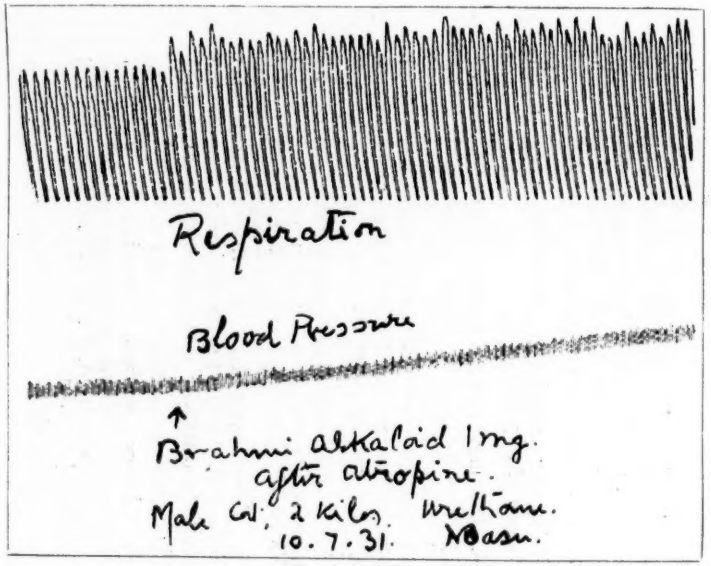
Graph No. X.



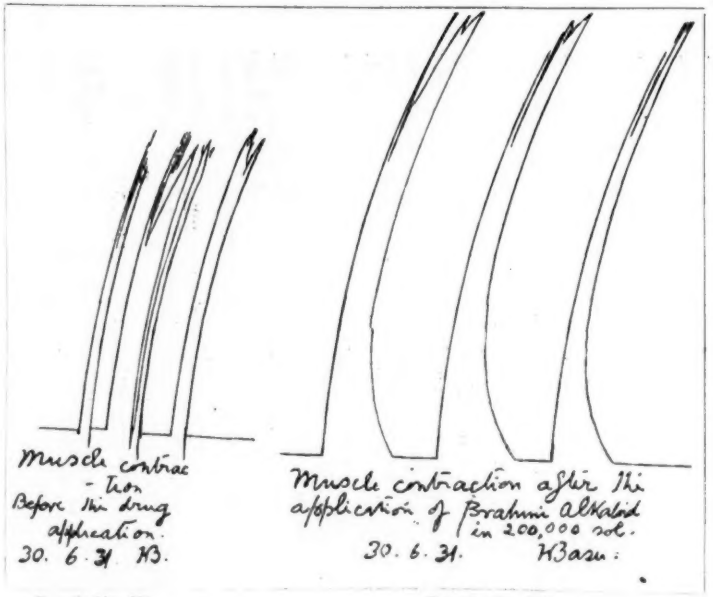
Graph No. VII.

Graph No. X.

Graph No. VII.

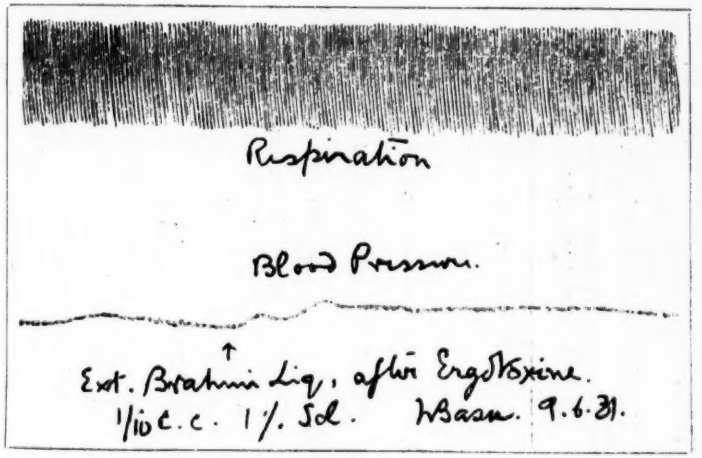


Graph No. II.

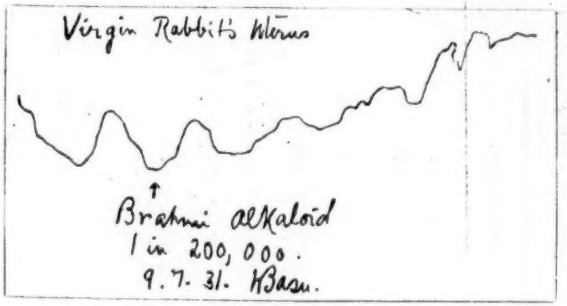


Graph No. XI.

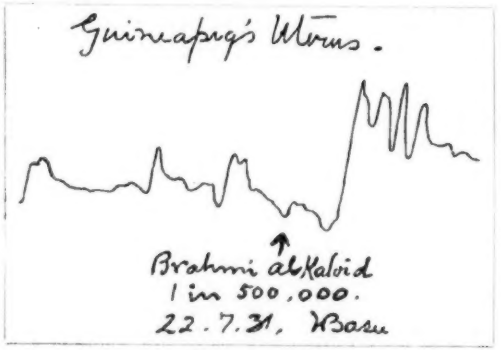
Graph No. XII.



Graph No. IV.



Graph No VIII.



Graph No. IX.

Comparison of the action of "Brahmine" the alkaloid of H. Monniera with Strychnine.

	Strychnine.	Brahmine (alkaloid) H. Monniera
1. Fatal dose for Frogs ...	0·25 mg.	0·5 mg.
2. Dose for convulsion ...	0·25 mg.	0·5 mg.
3. Therapeutic stimulant dose ...	0·05 mg.	0·1 to 0·25 mg.
4. Poisoning symptoms ...	Reflex irritability increased.	*Reflex irritability not increased*
	Tremors or involuntary twitches are seen in the limbs.	Tremors or involuntary twitches are present in limbs.
	Convulsions occur frequently before the animal succumbs.	Usually 1 or 2 convulsions occur before the animal is dead.
	Respiration is stimulated.	Respiration is stimulated.
	Blood pressure is raised.	Blood pressure is lowered.
	Heart-rate slows down.	Heart-rate slows down.
5. Pharmacological actions ...	Blood pressure is raised due to vaso-constriction.	Blood pressure is raised due to vaso-constriction.
	Heart is not affected directly.	*Heart is stimulated directly.*
	Respiration is stimulated.	Respiration is stimulated.
	Movements of plain muscles of intestine and uterus increased.	Movements of plain muscles of intestine and uterus increased.
	Muscular activity increased.	Muscular activity increased.

Use of Brahmi in Medicine.

In my practice among the Up-country (Marwari) people I come across cases of Remittent Fever and other low adynamic conditions, where the pills made with the leaves of the Brahmi plant combined with aromatics and in some cases with musk are administered largely by the Pandits and Marwari Kavirajs.

Whenever signs and symptoms of low vitality are noticed these Brahmi Pills are administered several times.

As the leaves contain the maximum amount of alkaloid, use of the powder of the dried leaves in 2 to 5 gram doses should be given a fair trial; it is less toxic than Strychnine and will not produce the reflex irritation, which is often noticed if Nuxvomica or Strychnine be administered for a long time and Herpestis is a direct cardiac tonic whereas Strychnine only indirectly stimulates the heart. Hence in all low conditions, where the heart becomes enfeebled this drug can be safely used for a long time to keep up the patient's strength.

It is always advisable to use the leaves (powdered) or decoction made with the leaves with 5 times the dose.

Summary and Conclusion.

1. Herpestis monniera belongs to the natural order, *Scrophularineae.*

2. It contains a powerful alkaloid, which we style "Brahmine", which in the dried leaves being 0·05% and in the dried stems 0·005%.

3. Toxicity of the alkaloid is very high. Frogs are killed within 10 minutes with a dose of 0·5 mg. per 100 grms. body weight. And rats and guinea-pigs are killed within 24 hours with a dose of 25 mg. per kilogram body weight.

Poisoning symptoms resemble very much like those of strychnine.

4. 0·5 mg. per kilogram body weight of cat produces fall of blood pressure through stimulations of the vagus. But about half of that amount of alkaloid raises the blood pressure through vaso constriction and stimulation of the cardiac muscles.

Alkaloid always produces stimulation of the respiration. And, in a dilution of 1 in 200,000 to 500,000 it stimulates every other system.

5. Therapeutic dose of the alkaloid also resembles strychnine in its actions; dose of the alkaloid "Brahmine" should range from $\frac{1}{8}$ to $\frac{1}{4}$ grain.

6. Watery extract contains only ·01% alkaloid after boiling, and therefore 5 times of the drug is to be used, if it is to be administered in decoction.

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Editorial Comments

Sanatoria for the treatment of tuberculosis are all too few in India. They are numerous in Western countries, where some of them are run on business lines. In India, it is hardly possible to make a sanatorium a business success. At the same time, India is in great need for the development of sanatoria for tuberculosis sufferers, and if we could rely upon public generosity the difficulty would be solved to some extent, but how much can be expected from that source? Assistance from Government seems to be out of the question. Without a large number of sanatoria for the huge population of tuberculosis sufferers in India, we have to look in the direction of home treatment for their needs. While we do not under-rate the benefit of a favourable climatic change, whenever possible, improvement in tuberculosis patients does not depend so much upon climate, as upon the special lines on which treatment is conducted and the measures that are taken. In the opinion of some of the highest authorities, climate as a factor in the treatment of tuberculosis is not an absolute necessity for success and most of the objects could be achieved by proper measures taken even in the home of the patient, whatever may be the climate of the locality. In this connexion, we make no apology for quoting the views of DR. ADOLPHUS KNOPF of New York, on the subject of climate in tuberculosis.

* * * * *

A long professional life, almost exclusively devoted to the study and practice of the prevention and treatment of tuberculosis, which began with an internship in the Los Angeles County Hospital and which is by no means yet completed, enables DR. KNOPF to form a reasonably accurate idea of the respective value of home treatment in home climates and the benefits that may be derived from sojourn of the tuberculosis invalid in the different climatic resorts as an adjuvant in the cure. He maintains "there is no *specific* climate for tuberculosis and that, if I had to choose between having a patient under special medical supervision with mental and physical rest in his home climate or sending him even to an 'ideal' climate where he would merely do as he pleased, I would prefer the former, believing he would have a better chance for recovery". His studies, visits to many American and European climatic health resorts, and a lengthy experience in private hospital, sanatorium and consultation practice have served to confirm this conclusion.

* * * * *

DR. KNOPF proceeds to enunciate certain maxims in the climatology of tuberculosis. Rest, as is well known, is of prime importance, and if the "sanatorium regimen" can be undertaken, climatic conditions are of secondary importance. But this must not be taken as a denial of the beneficial influence of certain climatic regions as a valuable adjuvant in the treatment of tuberculosis. The specific curative quality of any particular climate, however, DR. KNOPF regards as unscientific. PROF. EDW. G. JANEWAY, one of the greatest internists and medical teachers of his time, has said on his part that while a change from an unfavourable climate to a favourable one, or from a good to a better, must naturally be considered preferable, this cannot be regarded as an inflexible rule—a change even to a seemingly less favourable one may accomplish as much good in some cases. The native locality of the tuberculous must be taken into consideration when making a climatic change. Again, this rule must not be regarded as without exception, and one should be guided in a large measure by a patient's personal experience. The experience of one may suggest a cold climate and of another a warm climate, and of others a seaside resort. There exist also idiosyncrasies in regard to climatotherapeutics and aerotherapeutics as there exist in regard to hydrotherapeutics, electrotherapeutics and medicinal therapeutics.

High altitudes, low altitudes, hot and cold regions, seacoast and ocean climate, prolonged voyages, extreme dryness and moisture have all proved advantageous in numbers of cases. Patients with laryngeal disorders may often be benefitted by a change to a moderately high and warm moist climate, while a tendency to moist catarrh suggests extremely dry and hot climates, exempt from dust storms. In patients with pulmonary tuberculosis, a weak heart, distinctive heart or serious kidney lesions, emphysema, constant fever and extreme nervousness are contra-indications to high altitudes. As a rule, particularly in patients inclined to frequent hemoptysis, long distance journies should be made only with frequent rests and great altitudes approached only gradually. ROLLIER of Leysin has demonstrated the value of judicious solar therapy in high alpine-like climates. The gradual exposure to the cold air and actinic and ultraviolet rays of the sun has added greatly to the armamentarium in the treatment of tuberculosis of bones and joints particularly in childhood. In so-called contact cases, or those showing slight symptoms of incipience, there is no need for climatic change. It is merely necessary that the infected person should be removed from the environment and the case carefully watched and treated.

* * * *

Apart from pathological considerations, there are others to be taken into account. Experience has shown that when great climatic changes have been made, pa... frequently relapse when returned to their former homes. Sending a patient away against his wish often produced disastrous results, for mental depression retards recovery and aggravates pathologic conditions. On the other hand, if a patient has heard of a friend or relative who has been cured in this or that climate and he desires to go there, not to yield to his wishes would probably materially lessen his chance of recovery. A person's means should be sufficient to avoid all possible anxieties and worry in this respect. The ideal climate for the average patient with pulmonary tuberculosis in the earlier and more hopeful stages is one in which the extremes of temperature are not great, with only rare fogs or none, with a pure atmosphere, relatively little humidity, much sunshine, and with all the conditions permitting a life as much out of doors as possible. Seacoast climates in temperate zones are recommended in tuberculosis of the bones and joints because of the aseptic and ozonic quality of the air and the iodides and other salts suspended therein.

* * * * *

We are only too conscious how inadequately does our condensation convey DR. KNOPF'S views. It may pass, however, as tolerably correct. DR. KNOPF feels that many American phthisiotherapeutists now practising in the various health resorts and the great majority of physicians who make tuberculosis their speciality will agree with him in the essentials of the maxims he has propounded. He quotes the personal experiences of eminent phthisiotherapeutists, many intimately known to him, who were themselves tuberculous, who ascribe their recovery to the combination of climate and the hygienic and dietetic treatment, while on the other hand he points with admiration to men like BIGGS, BOWDITCH and OSLER, who taught the value of home climate and home treatment, though he is careful to add that even they appreciated the value of certain climates as an important adjuvant in the treatment of tuberculosis. Of his own experience he relates how in many years of labour in the tuberculosis clinics and hospitals of the New York Health Department he learned to appreciate the value of proper environments in phthisiotherapy. At the Riverside Hospital they received the tuberculous poor in all stages of the disease when they constituted a danger to their families. An almost immediate improvement in the condition of such patients was noticed after their removal from lower east or lower west side tenements into clean beds in hospital wards. In such cases, not climate but better air and environment were responsible for the improvement. When in California he found that well-to-do patients did remarkably well under careful medical supervision, but that even the glorious climate of California did not help those with

slender means, who after their means had been exhausted landed at the county hospital in the more advanced stages of tuberculosis to finish their days in that institution. It taught him the fallacy of sending patients to "ideal climates" when they had insufficient means and were unable to carry out the hygienic and dietetic regimen.

* * * * *

If we apply these views to India it would appear necessary to erect hospitals on the outskirts of cities (the outskirts are less congested) in preference to sanatoria in so-called health centres. It must be remembered that we have to provide for a very large number of people, most of whom are in extremely straitened circumstances.

* * * * *

Apart from rest, food, air and treatment that they would get at such hospitals they would not be far removed from their homes and relatives. They would be spared the expense and inconveniences of travelling long distances to health centres, and above all they would not constitute a potential source of infection to their families and public. So far as children are concerned, it would not be possible to treat them at distant sanatoria away from their parents in the city.

Medical News and Notes

[Items of news and notes of general interest to the profession for incorporation in this section from the members of the profession will be greatly appreciated—EDITOR]

Donations to a Hospital. The authorities of the Carmichael Medical College Hospitals (Calcutta) have recently received the following endowments and gifts to the Hospitals :

A sum of Rs 4000 from Sm. Raj Kumari Devi of Anguna. P. O. Berugram. Dist. Burdwan, through Dr. Sambhunath Hazra, for the endowment of a bed to be called Bhudeb-Rajkumari Bed.

A sum of Rs. 4000 from Sm. Kusum Kumari Dasi of Calcutta for the endowment of a bed in memory of her husband late Babu Jogendranath Sreemany.

100 pair of dhooties (9 yds. per pair) from Sm. Narayani Dasi of Calcutta for the use of the indoor patients.

* * * * *

Capital Grants to Hospitals. The Corporation of Calcutta has sanctioned the following grants to the undermentioned Calcutta hospitals at a meeting held on the 9th Sept., 1931.

A capital grant of Rs. 10,000 to the National Infirmary for the construction of a shed for tuberculosis cases.

A capital grant of Rs. 40,000 to the Chittaranjan Hospital for buildings and equipment for buildings and equipment for cholera patients.

A capital grant of Rs. 5,000 to the North Suburban Hospital (to be paid on condition that a Cholera Ward with 10 beds is opened.)

A capital grant of Rs. 5,000 to the Bengal Medical Institution and Hospital (to be paid provided an indoor hospital with 10 beds is opened.)

A capital grant of Rs. 25,000 to the Chunder Mohun Ghosh Memorial Sanatorium at Jadavpur (to be paid on condition that the number of beds is increased to 25.)

A capital grant of Rs. 30,000 to the Chittaranjan Seva Sadan for the Nurses' Block.

* * * * *

B. and O. Medical Council. The following will constitute the Behar and Orissa Council of Medical Registration on the expiry of the term of office of the present incumbents :

PRESIDENT.

Lt. Col. L. Cook, C. I. E., I. M. S., Offg. Inspector-General of Civil Hospitals, Behar and Orissa.

MEMBERS.

1. Lt. Col. P. S. Mills, I. M. S., Civil Surgeon, Ranchi.

2. Lt. Col. D. Coutts, I. M. S., Principal, Prince of Wales Medical College, Patna.

3. Dr. Naresh Chandra Mitra, M. B., Ranchi.

4. Major C. S. Ryles, O. B. E., Chief Medical Officer, Jharia Mines Board of Health, Dhanbad.

5. Major H. G. Alexander, I. M. S., Professor of Surgery, Prince of Wales Medical College, Patna.

6. Dr. Probodh Chandra Ray, L.R.C.P.,

L.R.C.S., L.R.F.P.S., Prince of Wales Medical College, Patna.

7. Dr. Phani Bhusan Mukharji, B.Sc., M.B., D.M.R.E., F.R.C.S., Radiologist, Medical College Hospital, Patna.

8. Dr. Dhirendra Nath Gupta, L.M.S., Assistant Surgeon, Sadar Hospital, Ranchi.

9. Dr. Sourindra Nath Majumdar, L.M.P., Bankipur, Patna.

10. Dr. Dwarka Prasad Dhar, L.M.P. Sub-Assistant Surgeon, Darbhanga Medical School, Laheriaserai.

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Anti-tuberculosis Campaign at Ranchi (B & O). Bengal, unfortunately having no sanatorium town of her own is compelled to send the sick people for recouping their health in the more salubrious climates of the various health resorts of its neighbouring province Behar and Orissa. Ranchi, the summer seat of the Government of that province has been a favourite resort for her tuberculous patients from a very long time. Owing to the suitability of climate the Behar Government has built a sanatorium at Itki, a few miles from Ranchi. Unfortunately patients from Bengal are not admitted there on provincial grounds. The result has been that the afflicted from Bengal are compelled to live in let out houses available at and near about Ranchi. They thus help to spread the infection for not living in conformity with the laws relating to hygiene and sanitation. The result is that the local people get more opportunity to get infected. The problem has become so acute that a good number of ladies and gentlemen, medical and non-medical, and of all communities, of Ranchi, have recently constituted themselves into an organising committee to fight this menace. They have elected a strong executive committee which again has appointed two very useful sub-committees *viz* : (1) Propaganda and Publicity Sub-Committee in charge of mass demonstration, lecturing with the help of magic lantern, leaflets and other literatures.

(2) Medical Sub-Committee in charge of a scientific tuberculosis survey, diagnosis of early and advanced cases, advising domiciliary, sanatorium and hospital treatment. Unfortunately there is no special tuberculosis hospital here. The tuberculosis ward of the local Sardar Hospital has also been closed. The new association is about to start tuberculosis dispensaries in the mohallas as soon as they get the necessary help and support. Already there have been four most useful and valuable lectures on the prevention of tuberculosis. A lady's section is also being contemplated.

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The Growing Menace of Quackery. The following resolution was unanimously passed by the Sind Medical Union at a meeting held on the 15th Sept. 1931 :

As the practice of the allopathic or Western system of scientific medicine requires for satisfactory qualification to practise a lengthy and exacting preliminary course of studies and training, and a higher standard of proficiency in general education and basic sciences and in physics, chemistry and biology and the medical sciences of anatomy, physiology, materia medica, pharmacology, pathology, bacteriology, clinical medicine, clinical and operative surgery, gynecology, obstetrics, pediatrics, ophthalmology etc.

And as there is a large and rapidly growing number of totally unqualified persons, chiefly of the class of ex-compounders, posing as allopathic physicians and exhibiting and using diplomas, degrees and designations, that are colourable imitations of allopathic diplomas, degrees and designations, or are ambiguous and misleading, in order to pass off as qualified allopathic physicians and to mislead the general public to believe that they had the same or a similar course of studies and training and examinations and are as qualified and efficient as qualified allopathic physicians, and as these unqualified persons are practising or claiming or attempting to practise the allopathic system of medicine for remuneration using or attempting to use allopathic methods of diagnosis of diseases and allopathic drugs and other remedies and methods of treatment, which methods of diagnosis and treatment they are utterly inefficient to practise on account of not being properly trained and qualified and as on account of their inefficiency they are doing great harm to the ignorant public who fall in their hands.

And as on account of the low standard of education in this country, even among the well-to-do, the public to their great harm are unable to distinguish between the duly qualified allopathic practitioner and the unqualified.

The Sind Medical Union is of opinion that under deterrent legal penalties such unqualified persons should be legally prohibited from :

(1) posing as allopathic physicians or practitioners in the Western system of scientific medicine,

(2) and/or exhibiting and using diplomas, degrees and designations that are colourable imitations of allopathic degrees, diplomas and designations or are ambiguous and misleading and liable to be mistaken by the ignorant public for allopathic diplomas, degrees and designations or equivalent to the same,

(3) and/or attempting to practise for any remuneration the allopathic system of medicine

and using allopathic methods of diagnosis of diseases and allopathic drugs, instruments, appliances and other remedies in the treatment of diseases, as is the normal legal practice of all advanced civilized countries as the U.S.A. etc.

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For the Relief of Blindness. Under the auspices of the All-India Blind Relief Association, a free dispensary for the treatment of diseases of the eye has been opened at Ajmer. The dispensary is located at Kalabagh, near the Civil Hospital.

One of the Association's ophthalmic surgeons is touring the Hyderabad State under arrangements kindly made by COLONEL NORMAN WALKER, Director of the Medical and Sanitary Departments in the State. The tour which, it is understood, will be to render medical relief will occupy about two months and will comprise visits to Aurangabad, Warangal and Raichur, with the local Civil Hospital as the headquarters in each case.

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7th Hyderabad Ayurvedic and Unani Conference. The seventh annual session of the Hyderabad (Deccan) Ayurvedic and Unani Conference commenced on the 25th September last under the presidency of His Excellency MAHARAJA SIR KISHEN PERSHAD BAHADUR, G.C.I.E., President of the Executive Council, Hyderabad State.

There was a large gathering of Hakims and Vaids. The MAHARAJA BAHADUR also opened the exhibition of Indian drugs and medicines. The Secretary of the Conference MR. MAKSOOD ALI in the course of his annual report said that the resolutions of the last Conference had been submitted to the Government but no reply had been received.

Ceylon Medical College. An extraordinary feature of the Ceylon Medical College examination results last time is that not a single candidate passed the final examination. Thus there is not even one new doctor to enter the profession this season. It is believed that this is the first time this has ever happened.

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How patients are exploited. Amazing charges of how certain doctors systematically swindle not only their patients but their fellow-consultants have emerged from the recent exposure in the "Sunday Express". A famous Harley street specialist explained how the trickery is carried on.

"There is a type of practitioner who is constantly summoning consultants by telephone, often in cases where no second opinion ought to be necessary. He pretends to explain the patient's financial position, and a consulting fee of perhaps £5. 5s. is agreed on.

"The consultation takes places, and the doctor who summoned the consultant leaves the room, saying that he is going to see about the fee. He returns with the relative for the usual interview, and after they leave he hands the consultant the agreed fee.

"The trick lies in the fact that the doctor has told the patient or the relatives that the fee is higher than it is and he has retained the balance for himself.

"There are several variants of this form of dishonesty, and reputable specialists are urging the General Medical Council to insist that consultants' fees should be paid in their presence".

The cynical commercialism of some doctors is illustrated by the case of the only child of a wealthy businessman.

A fretting child was taken to a so-called nerve specialist. After an elaborate examination he referred the case to an expert in diseases of Ear, Nose and Throat who thought an operation might be necessary but prior to that advised a blood test. The mother of the child already paid 150 guineas in fees and the ball was kept rolling. When she mentioned that the child had a slight digestive upset the first specialist emphasised the necessity of looking for an appendix. A surgeon was called in and he advised operation at a fee of 100 guineas.

The child's father who was away luckily returned at this crisis and at once consulted the family doctor who knew nothing about the visits to the specialists. The family doctor discussed the child's diet and ordered a change of food and air and she was in perfect health within a week.

Operations for appendicitis are a common form of fee racketeering among unscrupulous practitioners.

The first doctor hedges on giving an opinion and advises consultations. The surgeon called in says he cannot be sure, tells pathetic stories of the results of neglect in such cases, advises an operation, and assures the patient or the relative that if there is nothing wrong every one's mind will be at rest.

There are black sheep in every profession, but the average doctor detests the disrepute into which the racketeers and fee-snatchers are bringing the profession.

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Shortage of Nurses in Britain. The Lancet Commission on Nursing of which we informed our readers in the August 1931 issue of "The Indian Medical World" has issued an interim report consisting of a summary compiled by the statistician, MR. BRADFORD HILL, of the replies of 688 institutions employing 44,000 nurses

to the questionnaire sent to representative hospitals in England and Wales. MR. HILL finds that, roughly, one-fifth of all hospitals fail to secure suitable candidates as sisters and one-half fail to secure the staff nurses and probationers they require. The age at which probationers are accepted is eighteen or nineteen and as regards educational qualifications, nearly two-thirds of the hospitals demand secondary education. About one-third accept a slightly lower standard.

The working day, including the time off duty extends over 12½ to 13¼ hours in half of the hospitals and in nearly two-thirds of the voluntary hospitals it lasts 13½ to 14¼ hours, while the actual daily hours of work range from 9 to 11. The probationers' first pay varies from £12 to £41 annually. The Staff Nurses receive generally £50 to £65 and Sisters £70 to £85.

The wider sphere of employment open to women including better salaries and prospects in other occupations as also the greater freedom and social amenities is the chief reason put forward for the shortage of nurses, but there is no agreement regarding the solution.

The Commission reserves its own comments and recommendations for the final report which is expected this year.

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Native Medicine Men. MR. J. S. MARWICK, M.P. for Ilovo, Natal, has introduced a bill into the House of Assembly to control the native medicine men, whose activities in Natal have spread from the native kraals to the towns, much to the detriment of the European practitioners and chemists. MR. MARWICK proposes to amend the Medical, Dental and Pharmacy Act of 1928, Section 98, so as to prohibit native medicine men and women from practising within five miles of the area of any urban local authority, and from selling or prescribing "any preparation manufactured or compounded in accordance with a formula contained in any recognised formulary..."

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Foreign Medical Practitioners for China. Foreign doctors applying for Certificates for practising as medical practitioners must first forward their examination diploma and any other documents attesting their qualifications to the nearest Consul of their nationality for his inspection, with a request that he issues a certificate.

When the Consular certificate has been obtained it should be forwarded, together with a statement of the applicant's two 2-inch half figure photographs, registration fee of five dollars, and a stamp tax fee of two dollars, to the appropriate local government department (*i. e.* the Health Bureau ; or, if the district has no Health Bureau, then the Public Safety Bureau of the District Government), for transmission through the proper authorities to the Health Section of the Ministry of the Interior for consideration with a view to the issue of a Certificate.

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A New Hospital in Berlin. A new hospital, called the Martin Luther Hospital was recently opened in Berlin. It has been erected on behalf of the Lutheran Church and contains 450 beds. Its principal feature is that it has seven floors, whilst in Berlin formerly single-floor buildings were preferred for hospitals. The wards do not contain more than six beds each, whereas in public hospitals the wards contain up to 30 beds. The patients will thus enjoy more privacy and quiet than those in hospitals with large wards. There are six operation rooms, a lying-in room, rooms for special treatment, a radiographic and hydrotherapeutic department and a post-mortem room. A nurse's training school is connected with the hospital.

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Radium Substitute. In an international attempt to supplant radium and so break the monopoly which controls the world's supply, scientists have created a new weapon of such tremendous potency that they are almost afraid of it.

It is the X-ray developed to an intensity hitherto never approached. Radiologists in Britain, the United States, France and Germany are seeking to produce X-rays at voltages which range to millions.

In England, secret experiments are being carried out at Woolwich about which outside scientists know very little. A report of 500,000 volt tubes having been attained has leaked out but it is believed to be higher than that now.

Germans are working with 400,000 volts.

The world's greatest X-ray tube which will have a voltage of 900,000 volts and an intensity which is equivalent to 1,000 grammes of radium has just been installed in the Memorial Hospital, New York.

The highest voltage generally used in British Hospitals so far has been 200,000 volts.

There are only 250 grammes of radium in existence and the most used in even the wealthiest hospitals is eight grammes owing to the cost—£10,000 a gramme.

Will this powerful X'Ray tube supplant for good or ill ? Will it supplant radium ?

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Radio Fever helps to cure. DR. HINZE, an American working at the New York Physiatric Institute, has built, says "The Daily Herald," a

machine radiating short waves. These are made to pass through the body of the patient, causing the temperature to rise to high fever. Medical experts have found that the condition of persons attacked by paralysis is definitely improved if they are subjected to high fever at intervals. PROF. WAGNER JAUREGG, the eminent Viennese medical authority, discovered the treatment of infecting the patients with malarial fever. It is PROF. JAUREGG who now describes DR. HINZE'S "radio fever" process, the results of which, he says, are even more surprising than in the case of his own malaria treatment. Radio fever, it is pointed out, has an immense advantage over malarial fever, as it can more easily be watched and controlled. The radio cure, it is claimed, has already been successfully tried in a number of cases.

Medical Associations, Societies, etc.

Medical Societies, Associations, Unions etc. are invited to make use of this Section of the Journal. —EDITOR.

Tanuku Medical Association.

The following resolutions were passed at the anniversary meeting of the Tanuku Medical Association held at Tanuku (Madras).

1. This conference is of opinion that provision must be made in the register of the proposed All-India Medical Council to include the names of all those medical practitioners whose names now appear in the provincial medical registers instead of the medical graduates only.

2. This conference recommends that the course of study for the L. M. P. Examination be extended from 4 to 5 years and that the preliminary standard for entrance be raised and that examination for the licentiates be conducted by a statutorily constituted body such as the Bombay or Bengal College of Physicians or Surgeons.

3. This conference is of opinion that the Military Assistant Surgeons, *i. e.* I.M.D. should be open to all Indians.

4. This conference urges the medical practitioners to encourage the use of drugs, sera, vaccines, surgical dressings, surgical instruments and other appliances, etc., of Indian manufacture.

5. In view of the fact that extension of medical relief for the public in the rural areas can be secured only by the co-operation of the members of the independent medical profession, this conference is of opinion that the system of honoraries should be made inviting, the existing unsatisfactory conditions being removed.

6. The condition that the qualification of a person holding the Honorary Physician or Surgeon's post should be one registrable in Great Britain should be done away with and the vacancies that occur in the Services owing to retirement or otherwise of the salaried officers should be filled in by honoraries and further recruitment of salaried officers to these appointments should be stopped, except in the case of a few specified posts.

7. Whereas the existing system of medical inspection of the schools in this Presidency is both inadequate and unsatisfactory, this conference recommends to the Government to induce the managements of educational institutions to appoint qualified medical men in the staff, whole-timed or part-timed, to teach hygiene and physiology and to conduct medical inspection, preference being given to medical practitioners with experience resident in the locality.

8. This conference requests the Government to encourage rural medical practitioners by increasing the grants for medicines, in the case of dispensaries where the daily average attendance exceeds 30.

9. This conference suggests to the Government that a council consisting of the District Collector, the District Board President, the District Medical Officer and two independent medical practitioners of the district be constituted in each district to administer the scheme of rural medical relief.

10. This conference, while thanking DR. M. R. GURUSWAMY MUDALIAR, for his kind offices in securing for the L.M.Ps. admission for the final M.B., B.S. examination, subject to certain conditions, considers that the obstacles placed before the L.M.Ps. are really insurmountable in as much as it requires a further collegiate course in arts and in medicine, for a further period of 4 years, thus entirely disabling at last 95 per cent. of the L.M.Ps. from taking advantage of the concessions, requests the authorities of the University to remove this hardship, at least when the L.M.P. course is extended for a period of 5 years' standing to appear for the final M.B., B.S. examination without insisting on additional courses of study.

11. In view of the great demand for nurses and the inability of the Government to meet the same owing to lack of proper women applicants from *Andhra desha* and in view also of the present great unemployment of educated men in the middle classes this conference requests the

Government to try the scheme of training male nurses and entertain them in these hospitals where female nurses are not employed.

12. This conference is of opinion that the constitution of the Madras Medical Council is contrary to the spirit of modern times and so recommends to the Government and the Legislative Council to take up the matter to so change it as to abolish the present system of election of representatives in water-tight compartments and of nomination so as to obtain a majority of elected representatives in the council and to provide for an elected President.

13. This conference requests the Government to establish the proposed Central Medical Research Institute at Vizagapatam, in view of its possessing a well-equipped hospital, its growing importance due to the harbour and its bracing climate.

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The non-official section of the Tanuku Medical Association passed the following resolutions at their meeting held on 27-9-31.

(1) This Association thanks the committee for recommending equal facilities and opportunities for all grades of medical qualifications.

(2) This Association is of opinion that unless the duties of the three grades of Honorary Medical Officers, Clinical Assistant, Assistant Surgeon, Physician, or Surgeon are clearly defined it is not possible for the would-be applicants to take advantage of the scheme. Therefore this Association requests the committee to define the various duties before further action is contemplated.

(3) This Association is of opinion that all Honorary House Surgeons and Physicians should be paid an honorarium of not less than Rs. 50/- per month.

(4) (*a*) To make the Honorary System workable and attractive this Association is of opinion that Government should declare it as their policy that the paid medical staff will be replaced entirely (in a certain minimum period) as vacancies occur by the Honorary Medical Staff and further recruitment to paid services will be stopped hereafter.

(*b*) This Association further is of opinion that as a token of the above policy the Government appoint Honorary Medical Officers permanently in such of the posts as have fallen vacant, and for this purpose should invite applications from would-be candidates from among private medical practitioners.

(5) This Association recommends that a small representative committee of the Honorary Medical Staff of the Presidency be formed with the Surgeon-General as Chairman (for the present) to deal with matters concerning this side of the profession. The decision of the Committee be binding on the Chairman. In cases of difference of opinion the Minister-in-Charge should be appealed to who should have the final say in the matter.

(6) This Association is of opinion as regards the report in the Hindu of 22nd September, 1931 that Honorary Assistant Surgeons who hold M.B., B.S. degree have been empowered to grant medical certificates, that it is contrary to the spirit of clause 1 of recommendations of the committee on Honorary System and as such recommends that all Honorary Officers eligible to hold appointments to grades of at least 2 and 3 *i.e.* Honorary Assistant Surgeon irrespective of their qualifications, be empowered to issue certificates.

Madras Private Practitioners' Meeting.

A meeting of the private medical practitioners of the city of Madras was convened by DR. M. S. KRISHNAMURTHI AIYAR, M.B & C.M. on 4th October last. DR. T. V. RANGANATH RAO was in the chair.

Proceedings having commenced DR. NIMBKAR proposed that the meeting be dissolved and that the South Indian Medical Union be requested to hold a meeting of the private practitioners for the purpose of discussing about the Report of the Committee on Honorary Medical Officers. This resolution was seconded by DR. U. K. L. NARAYANA RAO and supported by DR. U. KRISHNA RAU.

The resolution being put to vote and lost DR. NIMBKAR left the hall followed by DRS. U. RAMA RAU, U. KRISHNA RAU, U. K. L NARYANA RAU, SANJEEVA RAU and one or two more. The meeting continued and the following resolutions were passed :

1. This meeting while approving the suggestion of the Committee to do away with the designation of Sub-Assistant Surgeon in the Honorary System of Medical Relief Scheme, wish to point out to the Government that the honoraries should be so designated as to connote the nature of work they do in a particular institution, whether as Assistant or Chief.

2. This meeting is of opinion that medicoes including those trained by the Government for Civil or Military duty passing from medical schools and colleges should undergo training as house surgeons and house physicians for one year before they are eligible for registration.

3. This meeting is of opinion that clinical assistants should be paid a monthly honorarium of Rs 50 in the moffussil and Rs 75 in the city and should be debarred from private practice.

4. That in the opinion of the meeting Honorary Assistant Surgeons and Physicians should have a fixed tenure for a period of 5 years to make room for other recruits and ordinarily these assistants should be selected from clinical assistants, but provision should be made for recruiting honorary assistants from private registered practitioners who should have been in acutal practice for at least 5 years and these should be given a carriage allowance of Rs 30 in the moffussil and Rs 50 in the city.

5. The tenure of office of Honorary Physicians and Surgeons should be ordinarily for 10 years, so as to make room for Honorary Assistants; and Honorary Assistant Surgeons and Physicians who have put in five years' service should be eligible for these appointments and also private medical practitioners of not less than 10 years' practice.

6. This meeting suggests to the Government that the recommending authority for honorary appointments should be a committee consisting of the Surgeon-General and two independent medical practitioners other than honoraries.

7. Regarding the Committee's recomendation XIV (2) concerning the appointment of honoraries for administrative work the meeting is of opinion that no honorarium should be paid but in case they are entrusted with the teaching work they should be given suitable allowance for such work.

8. This meeting is of opinion that there is no need for the provision of the confidential report even in a modified form and reports against or in favour of the honoraries should be made openly to the recommending authority.

The meeting discussed about the advisability of passing their opinion regarding the Indian Medical Council Bill. But as the whole Bill was not before them they passed the following resolution.

9. The meeting understands that a large section of medical practitioners registered in the provincial registers will not be treated as recognised medical practitioners for the purpose of the Indian Medical Council Bill and considers that this omission is unjust and detrimental to the interest and unity of the medical profession and will be definitely against the very aims and objects of the contemplated special legislation.

All-India Licentiates' Association.

MADRAS BRANCH.

Under the auspices of the All-India Licentiates' Association a meeting was convened by DR. D. V. VANKAPPA, Provincial Secretary on 11-10-31 at 98, Gordon Street, Madras to protest against the exclusion of the Licentiates in the purview of the proposed Indian Medical Council Bill. DR. U. RAMA RAU presided. The following resolutions were unanimously passed.

(1) The meeting strongly protests against the exclusion of the Licentiates and other medical diploma holders from Indian schools and colleges in the purview of the Indian Medical Council Bill and wishes to point out to the Government that the proposed legislation will not only not serve the interest of the medical profession in India and disorganize the same still further but also deface the very aims and objects of the bill in the matter of establishing "a uniform minimum standard of qualifications in medicine from all provinces such that persons attaining thereto shall be acceptable as medical practitioners throughout British India."

(2) The meeting appeals to all the branches of the Association in the country to organize protest meetings and carry on intensive propaganda.

(3) The meeting appeals to the Madras Medical Council to recommend to the Government to include in the proposed Indian Medical Register all registered practitioners in the provincial register.

That a deputation consisting of DRS. U. RAMA RAU, D. V. VENKAPPA, V. RAMA KAMATH, K. B. BHUJANGA RAU, R. RAMANUJAL NAIDU, K. S. SIVARAMA-KRISHNA IYER do wait on the Government to press the claims of the Licentiates in the proposed Indian Medical Council Bill.

The Madras Medical College Association.

The Madras Medical College Association was "at home" to the medical graduates of the year on the 8th August last with LT. COL C. A. F. HINGSTON, Principal of the Medical College in the chair.

After refreshments and a group photo, the professors and students held an enjoyable conversative.

The Secretary of the College Boys' Association proposing LT. COL HINGSTON as the President of the function enumerated the grievances of the Medical College, one of them being lack of a hostel and another, the need for a common hall. He hoped that the Retrenchment Committee would not apply their axe to the Hostel scheme that was in operation.

DR. A. LAKSHMANASWAMY MUDALIAR then delivered an illuminating address to the medical graduates of the year, in course of which he remarked that the medical profession was the noblest of all professions. One great defect in the profession in India was that it was not sufficiently assertive and vocal. Further they should try to bring more unity and harmony among their members. A harmonious spirit of co-operation would be the bulwark of their profession.

"Doctor Love" a farce adapted from MOLIERE's L'Amour Medicin, was then enacted. With the singing of national song and "God save the king," the function came to a close.

The Coimbatore Medical Association.

The annual meeting of the above Association was held in the Moses Gnanabaranam Eye Hospital on Thursday the 24th September.

The following office-bearers and members of the Committee for 1932 were duly elected :

President : Dr. K. Shiva Rao.
Vice-President : Dr. C. S. Ramaswamy.
Secretary : Dr. S. Gurubatham.
Executive Committee : Dr. S. K. Nathan. Dr. R. Sundarajan, Dr. P. K. Pratap and Dr. P. Kerala-varma.

The following are a few salient points from the Annual Report :

The Association has been in existence for the past 7 years. There are 40 members on its roll.

Regular monthly meetings were held throughout the year except in May. The average attendance at these meetings was 20.

A meeting was organised for condemning the high-handed action of the General Medical Council of Great Britain.

The financial condition of the Association is satisfactory.

Association Notes

Bengal Branch.

LECTURE BY PROFESSOR HIRSCHFELD.

A crowded meeting of medical men was held under the auspices of the Bengal Branch at the Association Hall on Sunday, the 4th October, 1931, at 7-30 p. m. when DR. MAGNUS HIRSCHFELD, President, Institute of Sexology, Berlin, gave a lecture on "Sex Pathology."

On arrival the Professor was given an enthusiastic reception and was garlanded amidst cheers.

In introducing the lecturer of the evening DR. HIRSCHFELD to the audience, the Chairman SIR NILRATAN SARKAR said :

"Gentlemen, it is unnecessary for me to take time in introducing DR. HIRSCHFELD to you. I would only say this much that I do not know which is more interesting the subject or the lecturer."

DR. HIRSCHFELD in his preliminary remarks expressed his great satisfaction in being invited to deliver a lecture on Sex Pathology in the Bengal Branch of the Indian Medical Association. He suggested that after his lecture he would be ready to answer any question which might be put to him, by the medical men present on points bearing on the subject matter of the lecture.

He then delivered his learned lecture. Printed in this issue of the journal (*vide p. p. 41*)

Questions.

DR. AMIYA MADHAB MALLIK said—I do not know whether the lecturer or the gentlemen present here believe in astrology. Many people in India believe that many unpleasant things in life might be avoided by consulting astrology in matters relating to marriage etc. There are types of men that are very very different as also there are types of women who are very very different. Suppose we marry a man to a woman who is astrologically very different, the inevitable result is unpleasantness and misery. That is the astrological point of view. We have had occasion to verify a few cases. I am specially interested in this point of view because latterly my attention has been drawn to a few cases where medical prognosis have been foreshadowed long before in what we call horoscope. It stands to reason that there is some thing behind the scene—some thing which we do not understand or which we do not care to understand. I believe that there is a science behind these phenomena which cannot be ignored. I am fully convinced that the changes in the astral bodies have a definite relation with the changes that take place in human body and mind. The Indian philosophers recognised this and they therefore traced the beginning of sexual physiology from the period of impregnation. We would like to know whether the attention of the learned lecturer has been drawn to this aspect of the sexual problem.

DR. B. SAHA enquired whether after the Great War and as a result of the extensive use of birth control methods, the women of the West had become less womanly and less influenced by sex incidents.

He also enquired whether there was any movement in the West for the propagation of good children. In ancient India—as described in Sanskrit epics the parents used to perform *tapas* for having good children.

DR. K. S. RAY.—I would ask two questions. We very often get cases of infantile uterus in women who show no development of the breast, no growth of hair in the pubic region, no menstruation. The uterus is very rudimentary. The ovaries are present in some cases but they cannot function effectively as the uterus is small. The patients want to have menstruation—they want the development of their breast etc. What is to be done in such cases ?

Secondly I would like to know if in Germany they have got statistics showing the number of marriages and the results of these marriages—whether happy or unhappy—whether followed by divorce or not before the War and after the War and if so, how the results of the marriages after the War compare with those before the War.

Reply.

In replying to the questions the lecturer said that he had no knowledge of astrology and of the influence of stars and other heavenly bodies on human affairs. He had no experience of astrological methods. In Germany there are astrologists but they are regarded more or less as laymen and not as scientists.

He believed that the condition of children to a very large extent depended on the condition—physical, mental and spiritual—of the parents procreating the children—the germ cells being a very important determining factor.

As regards the question of the connection of modern civilisation with the modern sex problems, the question was not free from difficulty. In many cases the influence of the modern civilisation was not good. The extensive use of birth control methods had no doubt made the sex problem more complex. But in support of birth control, it might be said that quality is always to be preferred to quantity.

In sex matters as in other things the customs and practices in the West and East differed. It was difficult to say which was better or which was worse. They were different.

The study of sex incidents began in the West about 30 years ago. The progress made was not much. Their only achievement was that sex incidents which were ignored before were now being observed.

With regard to the question of statistics of marriage in Germany before and after the War, they had got no such statistics. Such statistics would certainly be of great help to the study of the science. Some years back, some statistics were gathered as regards happiness in marriage and it was found that only 6 per cent. of the marriages were happy, 30% indifferent and the rest unhappy.

As regards birth control, it was not only very important but essential. Quality was better than quantity.

As regards the query about infantilism the manifestation of the disease was different in different cases. This was generally due to internal secretion and glandular formation.

DR. B. C. ROY on behalf of the Bengal Branch of the Indian Medical Association thanked the lecturer for the trouble he had taken to come over and deliver an address to them. His knowledge of the subject was profound and the method of his exposition—inspite of the difficulty of the language—had been of very great help to them to understand something of sex pathology that evening. He again thanked the lecturer.

Poona Branch.

THE FARADAY CENTENARY CELEBRATIONS.

Just a hundred years ago in the year 1831 a great experimental philosopher succeeded in discovering and announcing to the world a scientific principle on which most modern electrical engineering developments may be said to be based. The great principle is known as electromagnetic induction and MICHAEL FARADAY is the name of the discoverer. He was born in England in 1791 and after a life wholly dedicated to the advancement of science died in 1867 full of years and full of honors.

A public meeting was held on the 2nd instant under the joint auspices of the Indian Medical Association, Poona Branch, and the Ranade Memorial Institute in the M. E. Society's Hall to celebrate his centenary in a fitting manner. Two lectures were delivered on this occasion. KHAN BAHADUR BHARUCHA, President, Indian Medical Association, Poona Branch and PROF. M. R. PARANJPE of the Shiksha Vichar Mandal occupied the chair in succession. Two prominent members of the Maharashtra Sastriya Paribhasha Mandal were selected as lecturers.

The first lecturer, DR. M. V. APTE B.Sc., M.B., B.S., opened his speech with a few words about the life and work of FARADAY. He called to mind the fact that FARADAY was the son of a blacksmith ; he was apprenticed to a book binder in his boyhood and employed later as a laboratory assistant in the Royal Institution, London. In this institution he learnt his science under the guidance of SIR H. DAVY the great chemist of the early nineteenth century. The lecturer remarked that the discovery which was the subject of the present festivals was made by FARADAY two years after the death of his master SIR H. DAVY and thus proved beyond doubt the originality and the real genius the investigator

possessed. FARADAY'S worth, the speaker observed, lay not so much in the impetus that he gave to industrial activities as what he gave in to scientific research, infusing into it the spirit of coordination of various natural phenomena.

"Before the entry of FARADAY'S genius into the domain of science" the lecturer observed, "electricity, magnetism, light and mechanical motion occupied separate places in the minds of investigators. It was FARADAY, who strung all these "forces" of Nature together and exhibited their true and intimate relationship."

The lecturer then proceeded to explain the propriety of medical men taking part in these celebrations. He emphasised the fact that all sciences grow only by mutual help. He cited several instances of medical men playing a prominent part in physical investigations. He said that THOMAS YOUNG who upheld the Wave Theory of light against the blind followers of NEWTON, J. R. MAYER, who discovered the principle of Conservation of Energy in the course of his investigations on the human body and HELMHOLTZ who established that principle on a firm experimental and mathematical basis, were all very prominent medical men.

DR. APTE further said that the principle in question was fully grasped by FARADAY and announced by him in his papers written in 1834 and 1840 but did not gain the prominence it deserved. It was, the lecturer concluded, through the scientific labours of MAYER and HELMHOLTZ that the principle of conservation which had been completely submerged in the mass of FARADAY'S electrical researches restored to its proper place in Natural Science.

The second lecturer MR. S. K. APTE gave beautiful demonstrations of the principle of electro-magnetic induction by means of simple and impressive experiments. A magnet was first shown as being revolved through the agency of "Lines of Force" round a fixed wire carrying an electric current. Then the reverse experiment was shown in which a wire carrying an electric current and suspended so as to be free to revolve was made to revolve again through the agency of invisible "lines of force" round a fixed magnet. The next experiment illustrated how a wire suspended in a strong magnetic 'field of force' kicks itself out of the field so to say as soon as a current of electricity is sent into it.

The converse of this was then shown. A wire connected with a galvanometer (the scale and pointer of which were projected on the screen) was simply moved through the gap between the two poles of a horse shoe magnet, and it was at once apparent from the movement of the pointer on the screen that a current had been produced in the wire as it cut its way through the invisible field of "Lines of Force" ! Whenever a circuit cuts 'lines of force' or conversely 'lines of force' cut a circuit a current is induced to flow round it ; this, in short, is the great principle of electro-magnetic induction, ingenious application of which has led to the development of vast amounts of hydro-electric power supplies in modern times. FARADAY'S work brings home to us as nothing else does the fact that scientific experiment reinforcedly a truly scientific imagination will always have the best chances of wiring from Nature some of her great secrets. The following words of the lecturer deserve special attention :

"FARADAY was a genius : but had it not been for the volumes of the Encyclopaedia Britannica written in FARADAY'S own language which happened to fall into his hands as the boy FARADAY was learning his trade in a bookbinder's shop, or again had it not been for the fact that DAVY'S lectures were delivered in English and not in French or Latin it is certainly very doubtful whether his genius would have run into the channel for which it was best fitted and led its possessor to the summit of glory as it actually did."

A noteworthy feature of the two lectures of which a brief account has been given above was that they were delivered in fluent Marathi and were largely appreciated by the mixed audience consisting of boys as well as elderly people. Marathi booklets depicting the life and work of FARADAY and RAMAN, the foremost Indian physicist, have been published by the lecturers and are available to all who are interested in science.

Proposed Government Bill to Establish a Medical Council in India

No. 1494-H.

GOVERNMENT OF INDIA.

EDUCATION, HEALTH AND LANDS DEPARTMENT

Simla, the 31st August, 1931.

FROM

A. B. REID, ESQ., I. C. S.

Offg. Secretary to the Government of India,

To

ALL LOCAL GOVERNMENTS AND ADMINISTRATIONS.

Establishment of an All-India Medical Council

SIR,

I am directed to address the Government of Madras, etc.,/you regarding the establishment of an All-India Medical Council.

2. The Government of Madras/you were addressed on this subject before in this Department letter No. 903-Health, dated the 23rd May, 1928. The replies received to that letter showed that there was then no consensus of opinion in favour of the establishment of such a Council, and the local Governments which objected to the proposal did not change their views as the result of the conference of provincial representatives which was held in Simla on the 12th and 13th July, 1929, to discuss the whole question. The majority of the Ministers who attended that conference disagreed for one reason or another with the proposal, and the Government of India did not at the time proceed with it. The whole position, however, changed as a result of the General Medical Council in deciding, in February, 1930, to withdraw, temporarily, the recognition of the medical degrees of Indian Universities. If Indian medical students were to be relieved of the hardships to which the decision of the General Medical Council exposed them, it was imperative to resume consideration of the proposal for the establishment of an All-India Medical Council, as the creation of such a Council, offers the best, if not the only, prospect of again securing the General Medical Council's recognition of Indian degrees. The Government of India, who had never departed from their view that the proposal to establish an All-India Medical Council is sound in principle, accordingly arranged, with the concurrence of local Governments, to convene a second conference, in June of last year, to consider the matter afresh. All local Governments, except Assam, were represented at the Conference—Madras, Bombay, the Punjab and the Central Provinces by their Ministers in charge of the subject of Medical Administration and by their Surgeons General or Inspectors General of Civil Hospitals, Bombay also by their Member in charge of Medical Qualifications, and all other provinces, except Assam, which unfortunately was unable to be represented, by their respective Inspectors General of Civil Hospitals. All the Universities in British India which possess Medical Faculties were also represented, by one delegate elected by each such faculty. Copies of the proceedings of the Conference are enclosed herewith.

3. The views which the Conference expressed upon the subject of establishing an All-India Medical Council are contained in resolutions 3 to 6 passed at the meeting, which will be found at page 77 of its proceedings ; the other resolutions passed are not directly connected with this subject, and need not be considered here. The Conference unanimously resolved that the establishment of an All-India Medical Council is essential and acceptable in principle, and that a Bill should be drafted and legislation enacted to bring the Council into being as soon as possible. The Government of India think that the views which the Conference expressed upon the subject will command general approval, and that the establishment of the Council is the best and most practical way of affording relief to the Indian medical students who have suffered from the General Medical Council's decision. They have, therefore, gladly taken the first step towards giving effect to the Conference's view by drafting a Bill for circulation with a view to eliciting opinion. It will be observed that the Bill is not an amended copy of the Bill which was forwarded with this Department letter No. 903-H., dated the 23rd May, 1928. It is a completely fresh piece of work, conceived on simpler and more suitable lines than the previous Bill, and in general accordance with the views expressed at the Conference. Detailed explanations of individual clauses of the new Bill are to be found in the "notes on clauses" which are appended to it ; the remarks below explain the main features of the Bill in general terms.

4. **Composition of the All-India Medical Council.**—In framing their proposal for the composition of the Council, the Government of India have closely followed the views expressed by the Conference. The Conference recommended that the Council should consist of—

(*a*) A President ;

(*b*) One member to be nominated by each local Government ;

(*c*) One member elected by the Medical Faculty of each University in India :

(*d*) One member to be elected by the medical graduates of each province in which there is a medical register : and

(*e*) Three members nominated by the Government of India.

The Government of India think the proposals under, (*a*), (*b*) and (*e*) which provide for the adequate representation of the Central and Provincial Governments upon the Council will be generally approved. No questions are in their opinion likely to arise about any of them except, under (*a*), as regards the method by which the President should be appointed. The Conference recommended that the President should for the first three or five years be nominated by the Governnor General in Council, and that he should thereafter be elected by the Council itself. The Government of India are, however, disposed to doubt the advisability of this. In view of the close association which should exist between the Central Government and the proposed organisation, they think that it is probably desirable to reserve the power of nomination to this important post to the Governor General in Council perpetually. Clauses 3 and 3-A of the Bill have been drafted so a to give the choice between these alternatives. The Government of India will be glad to know which of these alternatives is preferred.

5. As regards the proposal referred to at (*c*) above, the Conference contemplated that every University in India which has a Medical Faculty should be entitled to elect one representative to the Council. The Government of India, however, think that for the present the scope of the Bill should be limited to universities which are in British India. They are also disposed to doubt whether it is necessary and desirable to grant each such University the right to elect a separate representative to the Council. If each University is granted separate representation, the Council will be automatically enlarged every time a new University with a Medical Faculty springs up or new medical faculties are established. With a view to curtailing the size of the Council as much as possible, the Government of India are provisionally of opinion that, if any province has more than one University with a medical faculty attached, those two or more Universities should be granted the right of electing one representative between them, rather than that each such University should be granted separate representation. The two possible courses are provided for at (*c*) of alternative clauses 3 and 3-A, and the Government of India will be glad to know which is preferred.

6. The recommendation made by the Conference as regards (*d*) in paragraph 4 above, was not reached without much discussion, and the alternative of granting representation on the Council to Provincial Medical Councils was considered at length. The Conference did not in the end accept the alternative, but the Government of India consider that there is much to be said for giving Provincial Committees of the Council, as defined in the Bill and referred to in paragraph 8 below, representation on the Council in place of graduates. The link between the Committees and the Council should be close, and an obivous way of securing that is to grant them the right of electing one member each to the Council. Should the view which the Conference held on this point be adopted, the Government of India consider that no person should be eligible to represent the medical graduates of a province unless he possesses the qualifications prescribed in (5) 3 of the Bill, which has been drafted with regard to the view of the Conference that representatives of graduates should have actual experience of the teaching of medicine. It would not appear necessary to prescribe such conditions of eligibility if it is decided to confer representa tion on representatives of provincial committees, and not upon graduates as such. The two courses possible are provided for in (*d*) of alternative clauses 3 and 3-A, and the Government of India will be glad to know which of them should be adopted.

7. If the views which the Government of India have expressed above are accepted, clause 3 should be preferred to the alternative clause of that number, and the Council should be composed as shown therein. It would consist at present of 28 members, which would appear neither too large nor too small for the work devolving on it.

8. **Committees of the Council.**—The Council in view of its size and the fact that it will be drawn from all over India will not be able to meet frequently. Clause 8 of the Bill provides that the Council shall meet not less frequently than once a year, but it will probably not be able to meet more often than that. Much of its work should therefore be done through a committee or committees. The Government of India think that it will be desirable to set up a small Executive Committee of seven members, composed as mentioned in clause 10 of the Bill, and to charge that Committee in especial with the inspection of examinations, as proposed in clause 21 of the Bill, so as to ensure that no delay occurs in the disposal of this very important part of the Council's work. The Government of India think, however, that, in addition to this, Provincial Committees of the Council should be formed, as provided in clause II of the Bill, in provinces in which Provincial Medical Councils are constituted. The formation of such Committees appears to the Government of India to be desirable so as to associate the provinces as

closely as possible with the Central organisation, quite apart from the necessity of giving the Council assistance with its work. The Government of India propose to assign such committees very important duties in connection, for instance, with the enrolment of candidates (clause 13), the erasure of the names of persons guilty of improper conduct (clause 15) and re-enrolment of those who satisfy the Committees that they deserved to be re-enrolled (clause 16).

9. **Functions of the Council. Inspection of examinations.**—It will be recognised that the functions to be assigned the Council will to a certain extent affect the powers which the provinces have hitherto enjoyed in the regulation of medical standards. There is, however, no alternative to this ; if the All-India Council is to do real and useful work it must exercise definite powers and rights. The Conference of June, 1930, recognised this, and agreed that it is necessary to ask the provinces to submit in certain matters to the jurisdiction of the council. The Government of India have, however, drawn the Bill on lines which affect provincial powers as little as possible, and have kept the point constantly before them in considering what the functions of the Council should be. One of the most inportant of them will be the inspection of the examinations held by medical institutions in British India for the purpose of granting recognised medical qualifications. Unless the Council is empowered through its Executive Committee to inspect such examinations, it will not be able to satisfy itself, or other provinces of India or other countries of the standard of the arrangements made for the teaching of medicine in India. Clause 21 of the Bill, which is generally in accord with the proposal made at the Conference of June, 1930, defines the duties which it is proposed to lay on the Executive Committee in this matter. The strength and composition of the agency which the Committee will employ for this work are left to the Committee's determination, but the Government of India anticipate that the Committee will employ the Registrar of the Council upon this work if, as is likely, he is a qualified medical man, and will give him the assistance of a number of Inspectors appointed temporarily for the purpose from time to time. It will be observed that the clause gives the Inspectors powers of report only, and that provision is made for copies of their report to be furnished to the institution inspected and to the Governor-General in Council

10. **Maintenance of a register, and recognition and withdrawal of recognition of medical qualifications.**—These important matters are dealt with in clauses 12, 18, 19 and 22 of the Bill. Under clause 12 the Council will maintain its own register, as is clearly necessary. In compiling it and keeping it up-to-date the Council will, however under clauses 13, 15 and 16, act through and with the assistance of the Provincial Committee and, as remarked in the notes on clause 13, will be able to overrule the Committees only in the circumstances provided for in clauses 13(2) and 15(2). Clauses 18 and 19 deal with the qualifications which candidates for enrolment must possess and procedure by which the list of recognised qualifications may be added to or cut down. The Government of India after very carefully considering what qualifications should be recognised at the start of the Council's existence, are of opinion that the only feasible course is to recognise those qualifications only, whether Indian, British, or foreign, which were recognised at the time that the General Medical Council took its action in February, 1930. All such qualifications are up to a standard which was formerly accepted ; the recognition of other qualifications should be left for consideration in accordance with the Bill. The Schedules to the Bill have been drawn up accordingly. Clauses 19(4) and 22 provide for their amendment, if amendment is necessary ; the latter clause provides, in the case of qualifications granted by British Indian institutions, that the institution and the local Government of the province within which it is situated may be referred to before recognition is withdrawn.

11. If clause 18 is adopted, licentiates will not be eligible for registration with the Council at the time that it comes into being. Nothing in the Bill specifically excludes licentiates permanently, but it does not appear likely that the Council would grant them recognition if it were applied for under clause 18 (2). The question of bringing licentiates within the scope of the All-India Council was raised in this Department letter No. 903-H., dated the 23rd May, 1928 ; the opinions then expressed were with very few exceptions, in favour of confining the Council to dealing with graduate qualifications. The Conference of June, 1930, was also of opinion that the Council should, at any rate at the start, deal only with such qualifications, and the Government of India think that in the present state of medical education in the country there is much to be said for that view. Organisations of licentiates have, however, petitioned the Government of India that they should be brought within the purview of the Council from the start. The Government of India will, therefore, be glad to be favoured with the local Government's/your opinion upon the subject.

12. **Enrolment, erasure and re-enrolment of names upon the Register.**—The procedure which the Government of India think should be adopted in connection with enrolment, erasure and re-enrolment of names are fully set out in clauses 13 to 16 of the Bill, and require no comment here in view of what is stated regarding them in the notes on clauses.

13. None of the other clauses of the Bill

need be mentioned here. Something should, however, be said on the financial aspect of the proposals, which is not referred to in the Bill. As the Council will be an organisation of the Central Government, the Government of India accept the expenditure on it, other than expenditure on travelling and other allowances of provincial representatives, as a charge against central revenues, and will not ask the provinces to contribute towards it. A point for consideration, however, having regard to the heavy expenditure, likely to be between Rs. 80,000 and Rs. 90,000 per annum, which the maintenance of the Council will involve, is whether fees should be charged from persons who register themselves with the Council. The Conference of 1930 recommended that no such fees should be charged. In support of that view it might be argued that registration with the Council will be of direct benefit only to Indian medical men who desire to practise their profession abroad ; as only a very small percentage of Indian doctors desires to practise abroad, registration would not directly benefit the great majority of persons who will enrol themselves with the Council. The charging of fees in such circumstances might act as a deterrent to registration. It might also be argued that if fees are charged, they will constitute a kind of subvention from provincial revenues towards the cost of an essentially central organisation, and the yield from fees would be insignificant in comparison with the cost of the Council. On the assumption that on an average about 300 Indian medical students graduate annually, fees for registration, if fixed at Rs. 75 each, would bring in only Rs. 22,500 per annum ; and in view of the rates which are charged for registration with provincial medical councils, the fee might well have to be fixed at less than Rs. 75. On the other hand it might be argued that the levying of a fee would not be likely to act as a deterrent to registration ; even if registration would confer direct benefits only on doctors who desired to proceed abroad, those who stayed in India would gain status and reputation by registering themselves with a body which would be of international standing and repute. It would appear fitting that graduate members of the medical profession should at the time of registration make a small contribution to the expenses of the Central Council which worked in their general interest, and, even if the yield from fees were small, it would do something to lighten the burden which the creation of the Council will impose upon the finances of the country and should not be sacrificed at this time of financial stringency. Under clause 23 (1) (*i*) of the Bill the matter is left for determination by issue of regulations of the Council. The Government of India would, however, be glad to be favoured in the meantime with the opinion of the local Government/your opinion on the point whether such fees should be charged and, if so, at what rate they should be fixed.

14. The Government of India consider that no further remarks need be offered in explanation of the Bill and that it should now be forwarded to local Governments and Administrations for expression of opinion. It should be understood that the views expressed above are provisional, and that the Government of India will come to no final decision as to the introduction of legislation or its scope until they have had the benefit of the opinion of the Government of Madras, etc./your opinion and the views of such individuals and associations as in the opinion of the local Government/your opinion are interested in the question and competent to advise upon it. I am to request that copies of this letter and the draft Bill may be circulated as widely as possible to all such individuals and associations, and that the Government of India may be furnished with the views of the Government of Madras, etc./your views and those of such individuals and associations on the question of establishing the Council and on the provisions of the Bill. If the proposal for legislation commands general assent, the Government of India intend to introduce a Bill at the earliest possible date. If a Bill is to be introduced at the next Delhi session it is essential that the local Government's reply/your reply should be received by the 15th November, 1931, and I am to ask that it may, if possible be sent by that date.

I have the honour to be,
SIR,
Your most obedient servant
A. B. REID,
Offg. Secretary.

A
BILL
TO

Establish a Medical Council in India and to provide for the maintenance of a British Indian Medical Register.

WHEREAS it is expedient to establish a Medical Council in India and to provide for the maintenance of a Register of qualified practitioners of modern scientific medicine in order to establish a uniform minimum standard of qualifications in medicine for all provinces such that persons attaining thereto shall be acceptable as medical practitioners throughout British India ; It is hereby enacted as follows :—

1. Short title, extent and commencement.—(*1*) This Act may be called the Indian Medical Council Act, 193 .

(*2*) It extends to the whole of British India.

(*3*) It shall come into force on such date as the Governor General in Council may, by notification in the Gazette of India, appoint.

2. Definitions.—In this Act, unless there is anything repugnant in the subject or context,—

(*a*) "British Indian University" means any university in British India established by an Act of the Indian Legislature or of a local Legislature and having a medical faculty ;

(*b*) "the Council" means the Medical Council of India constituted under this Act ;

(*c*) "medical institution" means any institution, within or without British India, which grants degrees, diplomas or licenses in medicine ;

(*d*) "medicine" means modern scientific medicine and includes surgery and obstetrics, but does not include veterinary medicine and surgery ;

(*e*) "Provincial Medical Council" means a medical council constituted under an Act of a local Legislature to regulate the registration of medical practitioners ;

(*f*) "Provincial Medical Register" means a register maintained under an Act of a local Legislature to regulate the registration of medical practitioners ;

(*g*) "the Register" means the British Indian Medical Register of medical practitioners maintained under this Act ; and

(*h*) "Regulation" means a regulation made under section 23.

3. Constitution and composition of the Council.—(*1*) The Governor General in Council shall cause to be constituted a Council consisting of the following members, namely :—

(*a*) the President, who shall be nominated by the Governor General in Council ;

(*b*) one member from each Governor's province, to be nominated by the Local Government of the province ;

(*c*) one member from each Governor's province, to be elected from amongst themselves by the members of the Medical Faculties of British Indian Universities within the province ;

(*d*) one member from each province in which a Provincial Medical Register is maintained, elected from amongst themselves by persons enrolled on such register who hold qualifications in medicine granted or recognised by any British Indian University or by any other medical institution which the Governor General in Council may specify in this behalf ; and

(*e*) three members to be nominated by the Governor General in Council.

(*2*) No act done by the Council shall be questioned on the ground merely of the existence of any vacancy in, or any defect in, the constitution of the Council.

3A. Constitution and composition of the Council.—(*1*) The Governor General in Council shall cause to be constituted a Council consisting of the following members, namely :—

Alternative proposals to clause 3

(*a*) the President, who shall be nominated by the Governor General in Council ;

[If sub-clause (*2*) is adopted, clause (*a*) will be deleted.]

(*b*) one member from each Governor's province, to be nominated by the Local Government of the province ;

(*c*) one member from each British Indian University, to be elected from amongst themselves by the members of the medical faculty of such university ;

(*d*) one member from each Provincial Committee of the Council as constituted under section 11, to be elected from amongst themselves by the members of such committees ;

(*e*) three members to be nominated by the Governor General in Council.

(*2*) The President of the Council shall be elected by the members of the Council from amongst themselves :

Provided that for five years from the first constitution of the Council, the President shall be a person nominated by the Governor General in Council who shall hold office at the pleasure of the Governor General in Council, and, where he is not already a member, shall be a member of the Council in addition to the members prescribed in sub-section (*1*).

4. Mode of election.—(*1*) An election under clause (*c*) of sub-section (*1*) of section 3 shall be conducted by Local Government, and under clause (*d*) of sub-section (*1*) of section 3 by the Registrar of Provincial Medical Register concerned, in such manner as it or he may think fit, subject to any instructions the Governor General in Council may issue in this behalf.

(*2*) Where any dispute arises regarding any election to the Council, it shall be referred to the Governor General in Council whose decision shall be final.

5. Restriction of nominations and elections.—(*1*) Save as regards the Council as first constituted under this Act, no person shall be eligible for nomination or election under clause (*b*), (*c*) or (*d*) of sub-

section (*1*) of section 3 unless he is enrolled on the Register.

(*2*) No person shall be eligible for nomination under clause (*d*) of sub-section (*1*) of section 3 unless he resides in the province concerned and, where a Provincial Medical Register is maintained in that province, unless he is enrolled on that register.

(*3*) No person shall be eligible for election under clause (*d*) of sub-section (*1*) of section 3 unles he has had five or more years' experience as a Professor, Assistant Professor, Lecturer or Reader in the medical colleges or schools affiliated to British Indian Universities.

The sub-clause does not apply to alternative clause 3A (*1*) (*d*).

(*4*) No person may at the same time serve as a member in more that one capacity.

6. Incorporation of the Council.—The Council so constituted shall be a body corporate by the name of the Medical Council of India, having perpetual succession and a common seal, with power to acquire and hold property both moveable and immoveable, and to contract, and shall by the said name sue and be sued.

7. Term of office.—(*1*) The President shall hold office at the pleasure of the Governor General in Council, and any other member shall hold office for the term of five years from the date of his nomination or election or until his successor shall have been duly nominated or elected, whichever is longer.

(*2*) Where the said term of five years is about to expire in respect of any member, his successor may be nominated or elected at any time within three months before the said term expires but shall not assume office until the said term has expired.

7A. Term of office.—(*1*) A member, other than a nominated President, shall hold office for the term of five years from the date of his nomination or election, or until his successor shall have been duly nominated or elected, whichever is longer.

Alternative proposals to clause 7 (*1*).

(*2*) An elected President shall hold office for a term not exceeding five years and not extending beyond the expiry of the term for which he has been nominated or elected a member of the Council.

8. Meetings of the Council.—(*1*) The Council shall hold its first meeting at such time and place as may be appointed by the Governor General in Council : and, thereafter, the Council shall meet at least once in each year at such time and place as may be appointed by the Council.

(*2*) Until otherwise provided by Regulations, ten members of the Council shall form a quorum, and all the acts of the Council shall be decided by a majority of the members present and voting.

9. Officers, Committees and servants of the Council.—The Council shall—

(*a*) elect from amongst its members a Vice-President ;

(*b*) constitute from amongst its members an Executive Committee, and such other Committees for general or special purposes as the Council deems necessary to carry out the purposes of this Act ;

(*c*) appoint a Registrar, who may also, if deemed expedient, act as Secretary and Treasurer ;

(*d*) appoint or nominate such other officers and servants as the Council deems necessary to carry out the purposes of this Act ;

(*e*) require and take from the Registrar, or from any other officer or servant, such security for the due performance of his duties as the Council deems necessary ; and

(*f*) with the previous sanction of the Governor General in council, fix the remuneration and allowances to be paid to the President, Vice-President, members, officers and servants of the Council.

10. The Executive Committee.—(*1*) The Executive Committee shall consist of seven members, of whom five shall be elected by the Council from amongst its members.

(*2*) The President and Vice-President of the Council shall be members *ex-officio* of the Executive Committee, and shall be President and Vice-President, respectively, of that Committee.

(*3*) In addition to the powers and duties conferred and imposed upon it by this Act, the Executive Committee shall exercise and discharge such powers and duties as the Council may confer or impose upon it by any Regulations which may be made in this behalf.

11. Provincial Committees.—(*1*) In any province in which a Provincial Medical Council is constituted, the members of the Provincial Medical Council who possess recognised medical qualifications shall form a Provincial Committee of the Council for the province.

(*2*) The registrar of a Provincial Medical Council shall be the Secretary of the Provincial Committee of the Council formed from such Provincial Medical Council.

(*3*) In addition to the powers and duties conferred and imposed upon it by this Act, a Provincial Committee shall exercise and discharge such powers and duties as the Council may confer and impose upon it by any Regulations which may be made in this behalf.

12. The Registrar.—The Registrar shall, subject to the control of the Council, maintain the British Indian Medical Register, and shall exercise and discharge such other powers and duties as the Council may confer or impose upon him by any Regulations which may be made in this behalf.

13. Procedure for enrolment.—(*1*) Applications for enrolment or for the amendment of any entry in the Register shall be made to the Secretary of the Provincial Committee of the province in which the applicant for the time being resides, and shall be disposed of by the Provincial Committee in accordance with this Act and the Regulations :

Provided that where the applicant resides for the time being in a province for which a Provincial Medical Council has not been constituted, the application shall be made to the Registrar and shall be disposed of by him in the aforesaid manner :

Provided further that where an applicant has not received orders on his application for a space of three months after he has made it, he may apply to the Council for enrolment, and the Council may take such action on his application as it may think fit.

(*2*) Any person aggrieved by an order of a Provincial Committee or of the Registrar under sub-section (*1*) may appeal to the Council.

14. Qualifications for enrolment.– Any person holding a recognised medical qualification may apply for enrolment, and, if he complies with the Regulations made under clause (*h*) of sub-section (*1*) of section 23, shall be enrolled on the Register.

15. Erasure of names of persons guilty of improper conduct.—(*1*) If it appears to a Provincial Committee of the Council that there is reasonable ground to believe that any person enrolled on the Register and residing in the province for which such Committee is constituted has been convicted, either in His Majesty's possessions or elsewhere, of a criminal offence implying a defect of character which unfits him to be a medical practitioner, or that he has been guilty of conduct improper to a medical practitioner, whether such offence or improper conduct has been committed before or after the enrolment of such person, or that he has been deprived of his recognised medical qualifications by the medical institution which granted them, the Committee may, after three months' notice served personally or sent by registered post to the last known address of such person, hear and consider the matter, and, if satisfied that such person has been so convicted or has been guilty of such improper conduct or has been so deprived, shall make a report to that effect to the Registrar, who shall erase the name of such person from the Register :

Provided that—

(*i*) where a person enrolled on the Register has been enrolled on a Provincial Medical Register, and his enrolment has been cancelled for any of the causes aforesaid by the authority of the Provincial Medical Council of the province concerned, the Provincial Committee concerned shall, without further inquiry, report such cancellation to the Registrar who shall erase the name of such person from the Register ;

(*ii*) in the case of a person enrolled on the Register and not residing in any province for which a Provincial Committee has been constituted, the powers and duties conferred or imposed upon the Provincial Committee by this sub-section shall be exercised and discharged by the Council.

(*2*) A person whose name has been erased from the Register in pursuance of a report of a Provincial Committee under sub-section (*1*) may appeal to the Council against the erasure.

(*3*) The name of a person shall not be erased under this section by reason only of his adopting or refraining from adopting the practice of any particular theory of medicine or surgery.

16. Re-enrolment after erasure from the Register.—(*1*) A person whose name has been erased from the Register in pursuance of a report of a Provincial Committee under sub-section (*1*) of section 15 may apply to such Committee for re-enrolment on the Register, and the Committee shall dispose of the application in accordance with any Regulations which may be made in this behalf.

(*2*) A person whose name has been erased from the Register by order of the Council under proviso (*ii*) to sub-section (*1*) of section 15, may apply to the Council for re-enrolment, and the Council may take such action on his application as it may think fit.

17. Other amendments of the Register.—(*1*) Any entry in the Register may be cancelled or amended at any time, by order of the Council, upon the ground of fraud or mistake.

(*2*) The Council may make Regulations empowering the Registrar to erase from the Register the name of any person with whom he is unable to establish communication.

18. Recognition of medical qualifications granted by medical institutions in British India.—(*1*) The medical qualifications granted by medical institutions in British India which are included in the First Schedule shall be recognised medical qualifications for the purposes of this Act.

(*2*) The medical institutions in British India which grant a medical qualification not included in the First Schedule may apply to the Governor General in Council to have such qualifications recognised, and the Governor General in Council, after consulting the Council, may, by notification in the Gazette of India, amend the First Schedule so as to include such qualification therein.

(*3*) Such notification may also direct that an entry shall be made in the last column of the First Schedule against such medical qualification declaring that it shall be a recognised medical qulification only when granted after a specified date.

19. Recognition of medical qualifications granted by medical institutions outside British India.—(*1*) The medical qualifications granted by medical institutions outside British India which are included in the Second Schedule shall be recognised medical qualifications for the purposes of this Act.

(*2*) The Council shall have power to arrange schemes of reciprocity as to the enrolment and registration of medical practitioners with the authority in any State or country outside British India which by the law of such State or country is entrusted with the maintenance of a register of medical practitioners, and in pursuance of any such scheme the Governor General in Council may, by notification in the Gazette of India, amend the Second Schedule so as to include therein any medical qualification which entitles the holder thereof to be enrolled on the register of medical practitioners maintained by such authority.

(*3*) Such notification may also direct that an entry shall be made in the last column of the First Schedule against such medical qualification declaring that it shall be a recognised medical qualification only when granted after a specified date.

(*4*) The Governor General in Council, after consultation with the Council, may, by notification in the Gazette of India, amend the Second Schedule so as to delete any medical qualification therefrom, or by directing that an entry be made in the last column of the Second Schedule against any medical qualification declaring that it shall be a recognised medical qualification only when granted before a specified date.

20. Power to require information as to courses of study and examinations.—Every medical institution in British India which grants a recognised medical qualification shall furnish such information as the Council may, from time to time, require as to the courses of study and examinations to be undergone in order to obtain such qualification, as to the ages at which such courses of study and examinations are required to be undergone and such qualification is conferred, and generally as to the requisites for obtaining such qualification.

21. Inspection of examinations.—(*1*) The Executive Committee shall appoint such number of medical inspectors as it may deem requisite to attend at any or all of the examinations held by medical institutions in British India for the purpose of granting recognised medical qualifications.

(*2*) Inspectors appointed under this section shall not interfere with the conduct of any examination, but they shall report to the Executive Committee on the sufficiency of every examination which they attend and on any other matters in regard to which the Executive Committee may require them to report.

(*3*) The Executive Committee shall forward a copy of any such report to the medical institution concerned, and shall also forward a copy, with the remarks of such institution, thereon, to the Governor-General in Council.

22. Withdrawal of recognition.—(*1*) When, upon report by the Executive Committee, it appears to the Council that the courses of study and examination to be gone through in any medical institution in British India in order to obtain a recognised medical qualification or that the standards of proficiency required from candidates at any examination held for the purpose of granting such qualification are not such as to secure to persons holding such qualification the knowledge and skill requisite for the efficient practice of medicine, the Council shall make a representation to that effect to the Governor-General in Council.

(*2*) After considering such representation, the Governor-General in Council may send it to the Local Government of the province in which the medical institution is situated, and the Local Government shall forward it, along with such remarks as it may choose to make, to the medical institution, with an intimation of the period within which the medical institution may submit its explanation to the Local Government.

(*3*) On the receipt of the explanation, or, where no explanation is submitted within the period fixed, then on the expiry of that period, the Local Government shall make its recommendations to the Governor Gereral in Council.

(*4*) The Governor General in Council, after making such further inquiry, if any, as he may think fit, may, by notification in the Gazette of India, direct that an entry shall be made in the First Schedule against the said medical qualification declaring that it shall be a recognised medical qualification only when granted before a specified date.

23. Power to make Regulations.—(*1*) The Council may with the previous sanction of the Governor-General in Council, make Regulations generally to carry out the purposes of this Act, and, without prejudice to the generality of this power, such Regulations may provide for—

(*a*) the management of the property of the Council ;

(*b*) the summoning and holding of meetings of the Council, the times and places where such meetings are to be held, the conduct of business thereat and the num-

ber of members necessary to constitute a quorum ;

(*c*) the powers and duties of the President and Vice-President ;

(*d*) the mode of appointment of the Executive Committee and other Committees, the summoning and holding of meetings, and the conduct of business of such Committees ;

(*e*) the conduct of business of Provincial Committees ;

(*f*) the tenure of office, and the powers and duties of the Registrar and other officers and servants of the Council ;

(*g*) the appointment, powers, duties and procedure of medical inspectors ;

(*h*) the conditions upon which persons entitled to apply for enrolment may be enrolled on the Register, the form and particulars of applications for enrolment on or for amendment of the Register, the procedure in regard to enrolment on and amendment of the Register and the particulars which shall or may be entered on the Register ;

(*i*) prescribing the fees which may be levied for anything done under this Act by or on behalf of the Council ; and

(*j*) any matter for which under this Act provision may be made by Regulations.

(*2*) Until the first Council is constituted under this Act, any Regulations which may be made under sub-section (*1*) may be made by the Governor General in Council ; and any Regulation so made may be altered or rescinded by the Council in exercise of its powers under sub-section (*1*).

24. Information to be furnished by Council, and publication thereof.—(*1*) The Council shall furnish such reports, copies of its minutes, abstracts of its accounts, and other information to the Governor General in Council as he may require.

(*2*) The Governor General in Council may publish, in such manner as he may think fit, any report, copy, abstract or other information furnished to him under this section or under section 21.

25. Commissions of Inquiry.—(*1*) Whenever it is made to appear to the Governor General in Council that the Council is not complying with any of the provisions of this Act, the Governor General in Council may refer the particulars of the complaint to a Commission of Inquiry consisting of three persons, two of whom shall be appointed by the Governor General in Council, one being a Judge of a High Court established by Letters Patent of the Crown, and one by the Council ; and such Commission shall proceed to inquire in a summary manner and to report to the Governor General in Council as to the truth of the matters charged in the complaint, and in case of any charge of default or of improper action being found by the commission to have been established, the Commission shall recommend the remedies, if any, which are in its opinion necessary.

(*2*) The Governor General in Council may require the Council to adopt the remedies so recommended within such time as, having regard to the report of the Commission, he may think fit ; and if the Council fails to comply with any such requirement, the Governor General in Council may amend the Regulations of the Council, or make such provision or order or take such other steps as may seem necessary to give effect to the recommendations of the Commission.

(*3*) A Commission of Inquiry shall have power to administer oaths, to enforce the attendance of witnesses and the production of documents, and shall have all such other necessary powers for the purpose of any inquiry conducted by it as are exercised by a Civil Court under the Code of Civil Procedure, 1908.

THE FIRST SCHEDULE.

(See section 18.)

Recognised medical qualifications granted by medical institutions in British India.

Medical Institutions.	Recognised medical qualification.	Abbreviation for registration.
University of Allahabad ...	Bachelor of Medicine and Bachelor of Surgery	M.B., B.S., All.
	Licentiate in Medicine and Surgery	L.M.S., All.
University of Bombay ...	Bachelor of Medicine and Bachelor of Surgery	M.B., B.S., Bom.
	Doctor of Medicine	M.D., Bom.
	Master of Surgery	M.S., Bom.
University of Calcutta ...	Licentiate in Medicine and Surgery	L.M.S., Cal.
	Bachelor of Medicine	M.B., Cal.
	Doctor of Medicine	M.D., Cal.
	Master of Surgery	M.S., Cal.
	Master of Obstetrics	M.O., Cal.
University of Lucknow ...	Bachelor of Medicine and Bachelor of Surgery	M.B., B.S., Lucknow
University of Madras ...	Bachelor of Medicine and Master of Surgery	M.B., C.M., Mad.
	Bachelor of Medicine and Bachelor of Surgery	M.B., B.S., Mad.
	Doctor of Medicine	M.D., Mad.
Punjab University	Licentiate in Medicine and Surgery	L.M.S., Pun.
	Bachelor of Medicine	M.B., Pun.
	Doctor of Medicine	M.D., Pun.
	Master of Surgery	M.S., Pun.

THE SECOND SCHEDULE.

(See Section 19.)

Recognised medical qualifications granted by medical institutions outside British India.

A. Registrable qualifications admitting primarily to the Medical Register granted by licensing bodies in the United Kingdom, as shown in Table (F) set out in the Medical Register for 1931 printed and published under the direction of the General Council of Medical Education and Registration of the United Kingdom in pursuance of the Medical Acts, 1858 and 1886.

B. Registrable qualifications granted by licensing bodies in British possessions, as shown in Table (I) set out in the said Medical Register, other than registrable qualifications granted by licensing bodies in India.

C. Registrable qualifications granted by licensing bodies in Foreign Countries, as shown in Table (J) set out in the said Medical Register.

NOTES ON CLAUSES.

Clause 1.—Sub-clause (*3*) will enable the Governor General in Council by taking advantage of section 22 of the General Clauses Act, to make all necessary arrangements so that the Medical Council of India may be constituted and ready to discharge its duties as soon as the Act comes into force.

Clause 2.—Most of the definitions are formal, but the special meanings assigned to "medicine" and "medical institution" are important.

Clauses 3 and 3A.—These two clauses are alternative drafts covering alternative proposals for the constitution of the Medical Council of India. In both forms, clauses (*a*), (*b*) and (*c*), providing for the nominated President, nominees of Local Governments and nominees of the Governor General in Council, are identical. The differences lie in clauses (*c*) and (*d*) which deal with the elected element on the Council.

Clause (*c*) in each case provides for the representation of the Medical Faculties of British Indian Universities, the first alternative giving one representative to each *province*, the second alternative giving one representative to each *University*.

Clause (*d*) provides for the representation of medical practitioners enrolled on Provincial Medical Registers. The first alternative provides for "direct election" by practitioners enrolled on the provincial registers who possess either British Indian qualifications or qualifications specially recognised in this behalf by the Governor General in Council. The second alternative provides for "indirect election" as follows. Under clause 11,

a Provincial Committee will be constituted, consisting of members of the Provincial Medical Council possessing qualifications entitling them to enrolment on the British Indian Medical Register. The composition of this group will vary in different provinces but most of its members will have been elected by medical practitioners or teachers, and some will have been nominated by various authorities. The group will have power, under the second alternative, of electing one of its members to the Medical Council of India.

The second alternative also contains alternative proposals regarding the appointment of the President. Clause (*a*) contemplates his nomination by the Governor General in Council; sub-clause (*2*) provides for his election by the members of the Council from amongst themselves, with a provision for his nomination by the Governor General in Council in the case of the first Council to be constituted.

Clause 4 makes simple provision for the conduct of elections and for the avoidance of deadlocks.

Clause 5 contains restrictions on nominations and elections. Sub-clause (*1*) will restrict provincial representatives of all kinds to persons who are enrolled in the Register, but makes an obvious relaxation of the rule in the case of the first Council, which will be constituted before the Register has been compiled. Sub-clause (*2*) secures that the Local Government's nominee will be a suitable representative of the medical practitioners of the province. Sub-clause (*3*) is intended to give "weightage" to the teaching interests and will, along with clause 3 *(1) (c)*, secure the presence in the Council of a body of men fully acquainted with the conditions of medical education throughout British India. It is not proposed to apply this restriction to the small body of possible candidates formed by the alternative clause 3A *(1) (d)*.

Clause 6 is a formal incorporating clause usual in such cases. It also gives a statutory name to the Council—"The Medical Council of India."

Clauses 7 and 7A.—These alternatives are designed to meet the alternatives proposed in Clause 3A, which provide for either a nominated President or for an elected President. Clause 7 (*1*) provides that a nominated President shall hold office at the pleasure of the Governor General in Council; clause 7A (*2*) provides that an elected President shall hold office for a term which may extend to five years but shall in no case run beyond the term of the Council which elected him. Both clause 7 and clause 7A provide for a normal term of five years of office for other members, with (*1*) a precaution, in the event of a hitch, for the continuance of the life of the old Council till the new Council is constituted, and with (*2*) an empowering provision whereby nominations may be made or elections held before the expiry of the normal five-year period so that the period may not be unduly prolonged.

Clause 8 makes some simple initiatory provisions for the meetings of the Council, which will remain in force only so long as the Council chooses. The only restriction placed on the discretion of the Council to conduct its own business in its own way will be the requirement that it must meet at least once a year.

Clause 9 relates generally to what may be termed the executive agencies of the Council. Clauses (*a*) to (*d*) require the Council to elect a Vice-President, to constitute an Executive Council and to appoint a Registrar; and empower it to constitute such other Committees and to appoint such other officers and servants as it deems necessary to carry out the purposes of the Act. Clauses (*e*) and (*f*) require no comment.

Clause 10 lays down the constitution, powers and duties of the Executive Committee, which will be the most important agent of the Council, discharging many of its duties, particularly in connection with the supervision of medical institutions. Sub-clause (*3*) refers to "the powers and duties imposed upon it by this Act." These powers and duties will be found in clauses 21 and 22.

Clause 11 provides for the constitution, powers and duties of another important agency of the Council—the Provincial Committee, which will have a preponderating influence in all matters relating to enrolment of persons on the Registers and the erasure of their names therefrom. The Provincial Committees will consist of those members of the Provincial Medical Council who possess recognised medical qualifications—see clause 18. The statutory duties of the Provincial Committees are given in clauses 13 to 16.

Clause 12 relates to the powers and duties of the Registrar, who will be the chief secretarial officer of the Council and will discharge all routine duties connected with the maintenance of the Register.

Clauses 13 and 14 relate to enrolment on the Register. Clause 14 requires each applicant to possess a "recognised medical qualification" (see clause 18), and also to comply with the further conditions and formalities prescribed by the Regulations. Clause 13 requires the applicant to submit his application to the Provincial Committee of the province wherein he resides, and empowers the Provincial Committee to pass orders of the Provincial Committee to the Registrar and the formal enrolment of the applicant on the Register will be settled by the Regulations.

The first proviso deals with provinces where there is no Provincial Medical Council, and therefore no Provincial Committee, by substituting the Council itself for the Committee in such cases.

The second proviso is a safeguard against hardship to applicants arising from undue delay by Provincial Committees.

Sub-clause (*2*) allows an appeal to the Council against an adverse order by the Provincial Committee. This sub-clause along with sub-clause (*2*) and clause 15 are the only instances in which orders of the Provincial Committee in regard to the contents of the Register are open to interference by the Council.

Clause 15 gives the procedure for the erasure of names of persons guilty of improper conduct. The initiative and power to pass original orders are given to the Provincial Committee, but sub-clause (*2*) provides an appeal to the Council. If the Provincial Committee reports adversely against the practitioner, the Registrar is required to erase his name from the Register, without inquiry.

The first proviso relieves the Committee of its duty of making an inquiry into a case where the name of the person concerned has already been erased from the provincial Register on an *ad hoc* inquiry.

The second proviso substitutes the Council for the Provincial Committee in provinces where there is no Provincial Committee.

Sub-clause (*3*) secures that the adoption of any particular theory shall not be construed as "conduct improper to a medical practitioner."

Clause 16 provides for the review of orders passed under clause 15, and will cover particularly those cases where the person whose name has been erased is able at some later time to show that he is again a fit person to be enrolled. The discretion to re-enrol is given to Provincial Committees, except in provinces where there is no Provincial Committee.

Clause 17 gives a residuary power to the Council to deal with cases of fraud and mistake and cases of unreported casualties.

Clause 18.—This important clause relates to medical qualifications obtained in British India, and deals with their recognition as qualifications entitling the holders to enrolment on the Register. In order to make a beginning, all those British Indian medical qualifications which were recognised up till 1930 by the General Council of Medical Education and Registration of the United Kingdom as qualifications registrable in the British Medical Register have been included in the First Schedule, and all are declared by sub-clause (*1*) to be recognised medical qualifications. For the future, sub-clause (*2*) provides that any medical institution seeking to have any of its qualifications recognised for the purpose of registration, may apply to the Governor General in Council who, after consulting the Council may amend the First Schedule so as to include the qualifications therein. Complete latitude is allowed to the Council and to the Governor General in Council as to the inquiry to be made, but the Council will, of course, employ its expert staff of medical inspectors and any other means at its disposal for obtaining information as to the standards of teaching and courses of study in the applicant institution.

Sub-clause (*3*) empowers the Governor General in Council to specify a date from which the recognition would have effect—a precaution to meet the case of an institution which has just attained the required standard.

Clause 19.—This clause is also important and deals with the recognition of medical qualifications obtained outside British India. Again, in order to make a beginning, the Second Schedule collects all those medical qualifications which could be obtained in the United Kingdom and elsewhere outside British India which the General Council in the United Kingdom recognises as registrable on the British Medical Register, and sub-clause (*1*) declares these to be recognised medical qualifications. For the future, the Council is empowered to enter into schemes of reciprocity with the registering authorities of other countries, in order to secure mutual recognition of medical qualifications. When such a scheme has been completed with another registering authority, the Governor General in Council is empowered to amend the Second Schedule by including therein any medical qualification recognised by a reciprocating authority. The reciprocating authority will make corresponding amendments in its own laws or regulations recognising the recognised medical qualifications of British India. The Council will not, of course, approach any country with such a scheme in view unless it considers that the registrable qualifications of that country reach the required strandards. Sub-clause (*3*), as with sub-clause (*3*) of the previous clause, empowers the Governor General in Council to recognise a medical qualification only when granted after a specified date.

Sub-clause (*4*) provides for the deletion of an entry from the Second Schedule. This serves a double purpose. It will avoid the retention on the Second Schedule of a medical qualification which has deteriorated; and will enable the Governor General in Council to take necessary action where a reciprocating country has not fulfilled its promises.

Clauses 20 and 21 deal with the supervision of medical institutions in British India which grant recognised medical qualifications. Clause

20 empowers the Council to call for such information and returns as it may think fit, in respect of such qualifications.

Clause 21 empowers the Executive Council to appoint medical inspectors, who may attend and observe the condition under which examinations for recognised medical qualifications are held. This section also prescribes how the reports of medical inspectors are to be dealt with.

Clause 22.—Sub-clause (*4*) of clause 19 deals shortly with the deletion of entries from the Second Schedule. Clause 22 deals in greater detail with the deletion of entries from the First Schedule. The Executive Committee will receive regular returns and information from medical institutions granting recognised medical qualifications, and regular reports from its own medical inspectors. These, supplemented by any *ad hoc* inquiry it may have to undertake, will enable the Council to know when any medical institution has allowed its courses of study and examinations to fall below the required standards. When the Executive Committee is satisfied that this has happened sub-clause (*1*) contemplates that it will make a report to the Council, that the Council will consider the whole case and make a representation to the Governor General in Council. Sub-clause (*2*) contemplates a further consideration of the case by the Local Government concerned, which is required to forward the papers to the medical institution concerned with any remarks it may choose to make. The medical institution is required to submit its explanation to the Local Government within reasonable time. Sub-clause (*3*) requires the Local Government to forward the explanation of the medical institution to the Governor General in Council, with the Local Government's recommendations thereon. Sub-clause (*4*) allows the Governor General in Council to make any further inquiry, if he thinks fit, and to pass orders. The Governor General may amend the First Schedule so as to withdraw recognition from the medical qualification concerned, with effect from a specified date.

The procedure is elaborate and ensures full deliberation. It gives every reasonable opportunity to the medical institution to improve its standards and to defend them ; and it accords full recognition to the authority of the Local Government in the sphere of medical education.

Clause 23 gives the Council power to make Regulations, with the previous sanction of the Governor General in Council, covering all matters ancillary to the provisions of the Act. Sub-clause (*2*) allows the Governor General in Council to make the first Regulations. Under section 22 of the General Clauses Act, 1897, he may do so before the Act comes into force so that the whole system may be in working order as soon as the Governor General in Council notifies a date of commencement under clause (*3*).

Clause 24 provides for reports by the Council to Government and for their publication.

Clause 25 is a safety precaution in the unlikely event of the Council abusing its powers. Its elaborate provisions explain themselves.

Obituary

Prof. W. E. Dixon.

1871—1931.

Students of medicine in India will be greived to learn the sudden death of PROF. W. E. DIXON, the leading British pharmacologist, at the comparative early age of 60. He first started his career as a demonstrator of physiology but soon turned to pharmacology, a subject which at that time was receiving little attention in his country. He was appointed professor of materia medica and pharmacology at King's College, London, and in 1902 assistant to the Downing professor of medicine at Cambridge University. In 1909 he became lecturer and in 1919 reader in pharmacology at the University. His researches covered a wide field and were of the first importance.

The drugs on which he made important researches include apocodeine, digitalis, cocaine, the derivatives of quinine, and alcohol. An excellent lecturer, he rendered the Cambridge school of pharmacology famous not only by his own researches but by the numerous ones of his pupils, whom he helped and stimulated. Since 1926 he had been joint editor of the Journal of Pharmacology and Experimental Therapeutics. He was also a member of the editorial committee of the British Journal of Pharmacology and the British Journal of Physical Medicine. He was prominent in compiling the first edition of the British Pharmaceutical Codex, which appeared in 1917, and in revising the subsequent editions. He contributed to HALE WHITE's "Materia Medica" and "HEFFTER's "Pharmacology." His Manual of Pharmacology" is a favorite textbook and has passed through many editions.

Prof. Oscar Minkowski.

1858—1931.

PROF. MINKOWSKI, one of the most celebrated physicians and pathologists of Germany, died in Wiesbaden on June 16th last. Born in 1858, he became privat-docent in Konigsberg at the age of

27 and six years later extraordinary professor in Strassburg. In 1900 he was appointed chief physician to the Cologne General Hospital and professor in the Academy of Medicine of that city, which has now become a faculty of the local university. Later he was appointed to the chair of medicine at Greifswald and then was invited to Breslau to succeed the late PROF. STRUMPELL. PROF. MINKOWSKI's work was of fundamental importance, especially in connexion with diabetes. In 1884 he detected the presence of oxybutric acid in the urine of diabetic patients, and formed the view that diabetic coma was due to an acid intoxication of the blood. He discovered later the part played by the pancreas in diabetes and his experiments formed the basis of the complex work on carbohydrate metabolism. PROF. MINKOWSKI also worked on the pathology of gout, liver diseases, and diseases of the respiratory organs. During the war he turned his attention to the study of the morbid condition caused by gas poisoning. He had a large practice as a consultant in Breslau until he retired in 1926 to spend the rest of his life in Wiesbanden.

Book Reviews

Small Pox—Its Prevention and treatment. *2nd Edn., by Dr. Abhoy Kumar Sarkar, M. B., D. P. H., Crown 8vo. pp. 132 with appendix pp. 28. Price Re. 1/-.*

The fact that this book has reached its second edition shows that it has filled a distinct want amongst the lay public as well as the team of public health workers in Bengal who cannot avail themselves of the English books on the subject, for want of sufficient knowledge of the English language.

It cannot but be admitted, however, that although the subject-matter has been approached from different angles the style has fallen short of our expectation.

The author should have been more elaborate on important points like methods of sterilisation of aprons, clothes (pp 27-28) of attendants and hands, face and nose-passages etc., but it is only possible that shortcomings of this nature will occur in course of compiling a volume. There are rather too many errors in spelling especially of technical terms and this we consider highly injurious to unqualified men for whom, we understand, the book has primarily been intended. In page 75 for example the word "vesicle" has been spelt as "vascecules".

The author alleges that the entire modern generation of young physicians are afraid even to tread the precincts of a house in which there has been an out-break of small pox (pp. 104). Such an imputation is most uncomplimentary and uncalled for.

Of all things we take strong exception to the prominence given in pages 98-99 to a secret remedy called "Small Pox cure" manufactured by a firm at Faridpur (where the author is the Health Officer.) While no attempt has been made even to mention the formula the name of the manufacturer, the price and a certificate about its excellence have been given. As it appears it may not be very wrong of people to think that the writer is interested in the firm or the remedy itself. For our part we fail to understand the motive behind such eulogy for an unknown quack remedy in a chapter which is supposed to deal with modern scientific treatment of small pox.

The book is divided into two parts, the first of which among other things deals with the nature, contagiousness, variety, differential diagnosis and prevention of the disease as also the special duties of the Health Officer, Health Instructors, Vaccinators and attendants and matters relating to vaccination. The second part deals with the treatment of the disease as adopted by various schools of practitioners. The Bengal Act V of 1880 on the laws in connection with vaccination has been added to the text as an appendix.

S. K. S.

Abdominal Pain. *By John Morley, Ch. M., F. R. C. S., Hon. Asst. Surgeon, Manchester Royal Infirmary, etc., Demy 8vo, pp. xv + 191. Published by E & S. Livingstone, Edinburgh, 1931. Sole Agents in India: Messrs. Butterworth & Co. (India), Ltd. Price Rs. 7/14/-.*

The author's reason for writing this book is his growing conviction that the prevalent theories of abdominal pain are in many respects physiologically unsound. MACKENZIE's "viscero-sensory reflex" has been holding the field so long. MORLEY has tried to demolish that. His thesis is that only somatic nerves are concerned in the production of accurately localised abdominal pain (with somatic manifestations of tenderness and rigidity). He has tried to accomplish this by careful pre-operative examination and verifying the findings by radiology and operation under local and spinal anaesthesia.

His theory has the merit of being simple.

"The issue must", however "be decided in the last resort not by claims to greater simplicity but by the test of clinical experience" MORLEY has also tried to clear our conception of "referred pain". The book is fascinating reading and opens up many other academic problems.

The book is recommended to all operating surgeons who will be able to put the theory to test. I must admit it has helped to clarify some of my own difficulties. *S.D.*

Hygiene for Nurses. *By John Guy and G. J. I. Linklater. Crown 8vo, pp. 212. Published by E & S. Livingstone, Edinburgh, 1930. Sole Agents in India, Messrs. Butterworth & Co. (India), Ltd. Price Rs. 3/12/-.*

A nurse who has to expose herself to all sorts of infection should have a clear knowledge of how to avoid dangers and protect herself as much as possible from the influences of her surroundings. This book contains a host of such information as is essential for a nurse who aims at rendering rational and scientific nursing to patients of different classes.

Written in easy style without entering into the details of the more scientific intricacies this small volume admirably fulfills the requirements of nurses going up for an examination on the subject. The standard of the text is uniformly maintained throughout the book and appropriate stress has been given on chapters according to their relative importance.

It must be said, however, that the book would have been more valuable in this country, if additional notes to suit the climatic conditions of the tropics could have been incorporated under each heading. For instance the chapter on Ventilation requires some modifications to suit the Indian standard while that on heating may be considered superfluous to a degree in the tropics. The chapter and appendix on food are incomplete from the Indian point of view. *S. K. S.*

Health and Hapiness *Vol xix, No. 6, June 1931. "Sanatorium Treatment" Number. Edited by Dr. Kartick Chandra Bose, M. B., 45, Amherst Street, Calcutta.*

This number of "Health and Happiness" has been specially devoted to tuberculosis and contains several papers dealing with the various aspects of the disease.

The informative article "Tuberculosis Sanatoria in India" gives a survey of practically all the sanatoria in existence in this country and deals with them province by province and therefore serves as a handy reference to medical men in selecting suitable places for their tuberculosis patients.

The general rules relating to the different sanatoria are found based on the same principle. A synopsis of these rules is given as a preliminary note and rules and particulars peculiar to certain sanatoria are mentioned along with a description of the location, management, maintenance, equipments, rules for admission etc.

We find there are 4 sanatoria in the Bombay Presidency with room for 150 patients, 3 in the Madras Presidency accommodating 307 patients, 2 in U. P. (one of which admits females and children only) for 135 patients and 1 each in the Punjab, Behar and Orissa, Bengal and Rajputna with 90, 52, 50 and 110 beds respectively. The last named is for female patients only. Details of some of the sanatoria were not unfortunately available.

It is much to be regretted that Bengal, where the incidence of tuberculosis is as high as in other provinces if not higher, lags behind all others in the matter of providing accommodation for her afflicted children. Incidentally, she owes her sanatorium at Jadabpur to the munificence of one of her sons—a victim to this fell disease who bequeathed his entire property valued at about 2 lacs of rupees for the treatment of consumptives. It is high time that the countrymen of this benevolent youth should exert their utmost to carry on this work with greater success and more efficiency as a fitting memorial to this patriot whose charity made it possible to give Bengal her first and up till now her only sanatorium.

The editor deserves our hearty thanks for this execution. *A. N. G.*

Current Medical Literature

Measuring the Speed of Circulation.

LEITE

Jour. Amer. Med. Assoc. June 27, 1931.

DR. NAIR LEITE applied the method described by DR. LIAN and MADAME E. BARRAS (The Journal, May 31, 1931, p. 1773) by using a solution of fluorescein in physiologic solution of sodium choride in thirty persons (ten normal and twenty with cardiac diseases in a condition of compensation) to measure the speed of circulation. The author made determinations in ten of the cardiac patients and in five of the normal persons with LIAN'S method and in the remaining fifteen persons (ten cardiac patients and five normal persons) she used a modification of LIAN'S

method. The author reaches the following conclusions: Fluorescein appears in the blood in normal conditions from twenty-five to forty seconds after the injection. The speed of circulation in a normal person is thirty seconds between the two upper limbs. The fluorescein reaches the maximum of visibility at from 90 to 150 seconds after the injection. The author's observations did not agree with those of LIAN and MME. BARRAS that fluorescein disappears three minutes after the injection. In the author's experiments the stain was observed in the blood even twenty minutes or half an hour after the injection. When the examination was made eight minutes after the injection the fluorescein was weak in visibility. The visibility of fluorescein in the tubes increases when the tubes are kept for examination after twelve to twentyfour hours. The conservation of the tubes for examination for some hours is important because they may then indicate differences in color that were not apparent when the tubes were recently prepared. More than once the author obtained precise differentiation of the color in tubes kept for twenty hours, which were at first very similar in color. The appearance and elimination of fluorescein do not seem to indicate a direct relation with the changes of the venous and arterial pressures, either considered in conjunction or isolated. Generally speaking, low arterial and venous pressures are associated with retardation in the appearance and elimination of fluorescein while, on the contrary, high venous and arterial pressures are associated with rather rapid appearance and elimination of the fluorescein. However, this does not occur in all instances. The prognostic value of the test is uncertain. Fluorescein appears in the urine of patients from the first minute of the performance of the test, and as a rule it is eliminated in about forty-eight hours. The test may be regarded as of mediocre value. The author's results differed from those obtained by LIAN and MME. BARRAS. She does not think however, that the modification of the technic caused the different results *A. N. G.*

The Treatment of Pernicious Anaemia with raw and cooked Pig Stomach.

Jour. Amer. Med. Assoc. Feb. 8, 1930.

Basing on the principle that gastric achylia is present in patients with pernicious anaemia the author used the uncooked stomach of the pig in the treatment of a series of 6 cases suffering from the disease. The interest lies in the fact that pig's stomach most resembles the human stomach structurally. But a note of warning is sounded in as much as there are certain parasites that largely and commonly abound in pigs and considerable caution has to be exercised in the proper preparation. The results obtained by this process is considered equally beneficial as those obtained by the liver treatment. This is shown by the general improvement of the patient as also the rapid increase of erythrocytes. *S. K. S.*

Uterine Haemorrhage with Special Reference to Malignant Disease.

WHITEHOUSE.

Lancet ccxx, 1 of 1931.

Sometimes the symptoms of carcinoma of the uterus appear to be so trivial that it is not usually considered as something other than a physiological phenomenon. The physiology of menstruation is discussed in order to explain the tendency of the uterus to irregular and excessive bleeding at menopause. Cases of post-menopausal haemorrhage include late ovulation and adenomatous polypus of the endometrium. This may occur at any age after puberty. In association with uterine cancer there may occur four types of uterine haemorrhage during or after menopause. Epimenorrhoea is associated with fibrosis of the uterus, menostaxis or prolonged menstruation is, according to the auther, associated with fibrocystic ovaries or local abnormalities of the endometrium. The most important form of bleeding unassociated with menstrual factors is that associated with coitus. The author states that pelvic examination and often curettage is necessary before the diagnosis of malignant tumour of the uterus can be excluded in cases where abnormal uterine bleeding is present.

S. K. S.

Contracted Pelves and Disproportion.

MCGOOGAN.

(Philadelphia Obstetrical Society Meeting. March 6, 1930.)

DR. MCGOOGAN reports on 471 cases of contracted pelves or disproportion between the pelvic canal and the child presented. These were selected from 5782 cases in which the pelves and the child were studied. This gives an incidence of 8·11 p.c. Of this number 220 or 46·7 p.c. of the patients delivered spontaneously and 251 or 53·3 p.c. required some operative interference. The cases were divided into 4 major groups *viz.*, flat (196 cases) generally contracted 72 cases, masculine 113 cases, diseased and normal pelves with a large child (47 cases). Cases in which the pelvic measurements were not complete in all details but in which there was enough disproportion present to require operative interference are considered in a fifth group (43 cases). The total maternal mortality for the group was 0·42 p.c. both deaths being due to streptococcic septicaemia. The fetal mortality was 10·8 p. c. of which

one third were due to intracranial haemorrhage. The other causes were destructive operations, cord conditions e.g. prolapse, prematurity etc., The fetal mortality in version and extraction may be attributed to prophylactic operations (28·5 p.c.) and emergency operations (66·6 p.c.) Surgical induction of premature labour gives satisfactory result so far as the fetal mortality rate is concerned but risks of infection result in higher maternal mortality. Caesarean section was done in 104 cases in which fetal mortality was 2·8 p.c. and the maternal nil. For patients with dead fetus and in cases of severe infection where caesarean is contra-indicated craniotomy has been considered the method of choice. *S. K. S.*

Corporeal and Cervical Caesarean Section.

PIPER & BACHMAN.

Surg. Gynec. Obst. Vol 49, 547,1929.

After an analytical study of results in cervical and corporeal caesarean section, the authors conclude that if done as elective operations before labour the low uterine incision does not differ much from that of the cervical incision so far as immediate convalescence is concerned. It is said that if done after labour has set in, the cervical section affords certain advantages with regard to safety, febrile morbidity and other factors of convalescence. The authors report, however, that in their experience, they found and believed that there was greater possibility of increased safety in the comparatively simple corporeal operation after the onset of labour in as much as in their hands the advantage of the cervical section over corporeal was almost negligible. While emphasising the value of good obstetric judgment in cases of doubtful disproportion the authors state that no assurance of safety in section removes the necessity for such judgment. More frequent test labours are advocated in cases where the elective section is resorted to in preference to the risks of operation late in labour or because of the difficulties met with in performing cervical section. The fact that the scar of the cervical section situated as it is in a quiet sector is less apt to rupture in later pregnancy and labour is according to the authors sufficient justification for resorting to the cervical section. They do not think that apart from this there is any reason such as smoother convalscence that may necessitate the adoption of the cervical operation as a routine method. *S. K. S.*

Hydrocele.

Proceeding of the Royal Society of Medicine.

XXIV. 1931. p. 971.

The paper reports that 5% solution of sodium morrhuate when used as an injection in the treatment of hydrocele proved very effective. In a series of twenty cases the procedure failed in only one *i.e.* in 5% of the cases.

Technique :—After taking the usual aseptic precautions the patient is allowed to rest on the bed and the selected area of the scrotum is thoroughly sterilised. Local infiltration anaesthesia is obtained by means of novocaine (2 per cent. solution) combined with adrenalin which is injected. The hydrocele is next aspirated empty for which a little care is necessary. The sac is washed thoroughly with sterile water and subsequently the sclerosing fluid which consists of 4-5 ccM of a 5% sodium morrhuate solution is introduced through the canula by means of a syringe. After the canula is taken out, the puncture is sealed with collodion. Attention has been drawn to the benefit derived by gentle massage of the scrotum for two or three minutes as this is said to assist in the permeation of the fluid to a very high degree.

The process may be repeated after a week's time but frequently this is considered unnecessary as hardly any fluid accumulates by then. It is very important that for about a month the patient should wear a suspensory bandage for the scrotum. *S. K. S.*

Treatment of Erysipelas with Vaccines.

W. T. BENSON.

(Lancet, Dec. 13, 1930.)

After a careful study of 235 cases of acute erysipelas cases the author is of opinion that treatment with stock or autogenous vaccines either strepto or strepto and staphylo is of no use. He found that the use of these vaccines did not :

shorten the duration of the attack ;
prevent exhaustive spread of inflammatory process ;
lessen the incidence of common complications such as abscesses or cellulitis ;
diminish the occurrence of relapse ;
prevent recurrences, or
have any appreciable effect in diminishing the mortality from the disease. *A. N. G.*

Correspondence

[The Editor is not responsible for the views expressed by correspondents]

Re : "Human Rhinosporidiosis"

Published in the June 1931 issue of the Indian Medical World.

DR. M. NARAYANA PAI, M.B., B.S., Department of Pathology, Medical College, Madras writes under date of August 7, 1931 :

In the June 1931 issue of the Indian Medical World, I find in an article on Human Rhinosporidiosis by DR. P. K. KURUP, that the first case of Human Rhinosporidiosis in the female in the Madras Presidency was reported by him on the 15th November, 1930. I wish to point out that this statement is incorrect. Dr. P. V. CHERIAN and DR. A. VASUDEVAN of Madras have reported a case in a female in the August 1929 issue of the Journal of Laryngology and Otology and I have reported two cases in females in the October 1930 issue ef the Madras Medical Journal *i. e.*, one month earlier than DR. KURUP's case.

The letter was referred to DR. KURUP and we received the following note in reply :

My thanks are due to Dr. M. NARAYANA PAI, M.B., B.S., of Madras for kindly reporting the fact to the Indian Medical World and furnishing me with the reprints of the articles mentioned in his letter.

On page 157 of the Indian Medical World, under "Human Rhinosporidiosis" I had stated "The first case of Rhinosporidiosis in a female is recorded by me in the Madras Presidency". This statement is now found incorrect, *in the light of the above publications.* I was not able to get the information though very great search was made by me. DR. CHERIAN's case has undoubted priority and it is very interesting and it is a case of nose infection extending to the pharynx. My case was primary infection of the pharynx in a female without nose infection at all. The case report of Dr. CHERIAN does not show to what caste the patient belonged. It would be interesting to know if she was a Mohammadan as my case also was in a Mohammadan female and it was published in the Indian Medical Gazette, May, 1931.

I did not yet find a case of Rhinosporidial infection (primary) of the pharynx in a female (without Rhinosporidial affection of the nose) published in the Madras Presidency, other than one published by me in the Indian Medical Gazette and quoted in the Indian Medical World. DR. CHERIAN's case is perhaps the first case *in a female* in the Madras Presidency ever published and mine is perhaps the first case of *primary pharyngeal affection* without nose infection *in a female* in the Madras Presidency.

Appeal for Fund for General Organiser

The Central Council of the Indian Medical Association feel that much more energetic measures are needed for the establishment of branches of the Association all over India than those made hitherto, and that it is necessary to delegate this work to an officer who would be able to give undivided attention to this particular duty.

Col. Bhola Nauth, I.M.S. (Retd.), having very kindly placed his services at the disposal of the Central Council for this purpose, has been appointed as the General Organiser.

For the work Col. Bhola Nauth will have to travel a good deal about the country and there will also be incidental expenses, and as these cannot be met from the usual sources of the Association, it has been found necessary to institute a special fund for the purpose.

The Central Council are confident that members will immediately realise the importance of the measures proposed and that there will be no hesitation on their part in coming forward with contributions.

Any sum, large or small, wiil be gratefully accepted by the Hon. Joint Secretaries at their office at 67, Dharamtala Street, Calcutta, and will be acknowledged by them.